CULTURAL ASPECTS OF PARASUICIDE:

AN EMPIRICAL INVESTIGATION

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ABSTRACT

The purpose of this study was to devise an empirical test of the hypothesis that geographical areas with high parasuicide rates (HRAs) are characterised by a distinctive subculture. This subculture, maximally expressed among the working class living in a predominantly working class area, is held to be distinct from the dominant local culture, though not in every respect. It is expected to facilitate parasuicidal behaviour to a considerable degree. A secondary hypothesis states that cultural differences ("cultural distance") between parasuicides and the general population will be relatively more pronounced in the LRA than in the HRA.

Design and Methods

Data were gathered on four separate samples in Edinburgh: two groups of parasuicides, one from a HRA, the other from three LRAs; and two groups of general population controls matched pairwise with each parasuicide by sex, age and area of residence. The major hypothesis was tested by comparing the meaning systems of the control groups. Subsequently, evidence relating to the secondary hypothesis was explored by comparing the extent of "cultural distance" between patients and controls in the two areas.

Four instruments were used to test middle-order hypotheses relating to specific elements of the cultural system. The Value Orientation Schedule (VOS) operationalises the more abstract, general dimension of the value complex. The Ways of Behaving Instrument (WOBI) is designed to provide empirical measures of normative

evaluations and expectations of suicidal behaviour and other officially deviant acts. The Case Vignette Instrument (CVI) was devised to capture the cognitive, affective and moral evaluations of parasuicide. Finally, the Contact with Behaviour Schedule (CBS) measures the extent, quality and type of lifetime encounters with parasuicide and suicide. Background sociodemographic data on each subject were also gathered. Adequate test-retest reliability and validity is demonstrated for each instrument.

Results

Empirical evidence undoubtedly supported the prediction of a meaning system in the HRA which was distinctive from that found in the LRA. However, not all differences between control groups were in the expected direction. The WOBI provided evidence of more toleration in the HRA of deviant behaviour in general, although parasuicide was equally proscribed in the two areas and was actually rated by HRA controls the most deviant of all behaviours listed in the WOBI. Findings on the CVI were perhaps the most unexpected, with HRA controls being significantly less understanding of parasuicide, and considering it to be more immoral and sanctionable than did LRA controls. Overall, lifetime contact with suicidal behaviour was found to be equally extensive in the two areas, although more intimate experience and personal involvement was reported in the HRA. Detailed analyses of within-area differences relating to all measures and instruments provided little support for the secondary hypothesis: cultural distance was similar in both groups. Possible explanations to account for the unexpected findings were proposed, and the thesis concludes with suggestions for further research utilising a socio-cultural perspective.

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The research described herein is entirely my own,

and the thesis has been composed by myself

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"Sociologists and psychologists believe themselves obliged to prove the impossible, that their research serves something: without exception, they serve at best only to clarify, which constitutes a necessary and sufficient justification."

(Baechler, 1979: 34)

Chapter 1 INTRODUCTION

While the study of deviance has been subject to changing fashions of concern, suicidal behaviour has always exercised an irresistible fascination and lure for generations of sociologists. However, even a passing scrutiny of the countless books and articles produced on the topic since Durkheim's seminal work (Durkheim, 1897 (1952)) reveals a curious finding: namely, that little sociological interest has been shown in non-fatal suicidal behaviour ("attempted suicide") as a separate research domain. As Wilkins (1967: 287) notes, "the major statements of Durkheim, Gibbs and Martin, Henry and Short, and many others, have no place for those who have not died". Others urge more investigation of attempted suicide, but only as a means of "getting at the meaning of suicide to the person who committed it". Since the researcher cannot interview the suicide victim, she/he should instead "begin a concentrated study of those who attempt suicide" (Henslin and Campbell, 1974: 181); these are treated, then, as proxy suicides. Although there has been a massive amount of empirical research by psychiatrists, psychologists and epidemiologists on "attempted suicide", less than twenty years ago Wilkins (1967) described one of the purposes of his paper as an attempt to introduce this unknown body of data to sociologists. In the intervening period, the situation has changed very little. We continue to ignore those (the vast majority) whose suicidal or suicide-like behaviour is not "successful".

What, then, is "parasuicide" and can the attempt to treat it as an analytically separate research topic be defended? I distinguish between two types of suicidal behaviour (defined as a deliberately

self-harmful act): those with fatal outcome (i.e. suicide) and those with nonfatal outcome. Until the mid-1960s the latter type was invariably referred to as "attempted suicide". However, in 1965 Kessel delivered his influential Milroy lectures in which he referred throughout to "self-poisoning" rather than to "attempted suicide"

> "for I consider the latter term to be both clinically inappropriate and misleading. It is true that in the popular mind deliberate self-poisoning is linked, linked indeed romantically, with the idea of suicide. It is true that some of our patients had done all they could to encompass their deaths; that minority can be said to have failed at suicide. But for four-fifths of the patients the concept of attempting suicide is wide of the mark. They performed their acts in the belief that they were comparatively safe - aware, even in the heat of the moment, that they would survive their overdosage and be able to disclose what they had done in good time to ensure their rescue. What they were attempting was not suicide." (Kessel, 1965: 1339).

In a letter written four years later to the British Journal of Psychiatry, Kreitman et al. drew attention to the universal dissatisfaction with the term "attempted suicide", "for the excellent reason that the great majority of patients so designated are not in fact attempting suicide." (Kreitman et al., 1969: 746). However, they noted that none of the alternative terms had found general acceptance, and expressed doubts about Kessel's proposals of "deliberate self-poisoning" and "deliberate self-injury". They propose instead the term "parasuicide":

> "What, then, is our alternative? It appears that what is

required is a term for an event in which the patient simulates or mimics suicide, in that he is the immediate agent of an act which is actually or potentially physically harmful to himself. Yet the 'attempted suicide' patient is not usually addressing himself to the task of self-destruction, and rarely can his behaviour be construed in any simple sense as oriented primarily towards death. To designate this act, which is like suicide yet is something other than suicide, we now propose the term 'parasuicide'." (Kreitman et al., 1969: 747; emphasis in the original.)

In a subsequent book, Kreitman commented:

"A terminological rather than a major conceptual innovation was introduced by the term 'parasuicide' ... in an attempt to supply a word which would indicate a behavioural analogue of suicide, but without considering a psychological orientation towards death being in any way essential to the definition." (Kreitman, 1977: 3; emphasis in original.)

A common element in both suicide and parasuicide is the presence of a deliberate intention to endanger the integrity of the biological organism and influence the potentiality of further conscious experience. Shneidman (1966) uses the term "cessation" to refer to the final ending of consciousness, and describes four basic orientations which the individual may adopt towards his own demise: intentioned (where "the individual plays a direct and conscious role in his own demise"), subintentioned ("the individual plays an indirect, covert, partial, or unconscious role ..."), unintentioned ("the person psychologically plays no significant role ...") and

contraintentioned ("an individual who uses the semantic blanket of 'suicide' with a conscious absence of any lethal intention"). Although some "suicides" will be unintentioned (accidents), most are probably cessation-intentioned, while the majority of acts of deliberate self-harm are cessation-unintentioned or cessation-contraintentioned. This is not, of course, to deny that some para-suicides are cessation-intentioned (Kessel, 1966). However, as Stengel and Cook (1958) pointed out in their influential monograph, the great majority of patients usually described as "attempted suicides" do not have an unequivocal wish to die. While the variety and complexity of motiviations for "attempted suicide" has been illustrated by a number of authors (e.g. Kreitman, 1973; Birtchnell and Alarcon, 1971; Bancroft et al., 1976, 1979; Stengel, 1960), most would probably agree with Kessel's view (Kessel, 1966) that what is more commonly sought is not the cessation of consciousness, but its interruption, defined by Shneidman (1966) as "the stopping of consciousness with the actuality, and usually the expectation, of further conscious experience. It is a kind of temporary cessation".

Stengel and Cook (1958) were the first to draw a clear distinction between (completed) suicide and "attempted suicide". Decrying the traditional conceptualisation of attempted suicides as merely failed suicides, they not only pointed to the complexity of motivation in nonfatal suicidal behaviour, but also identified important epidemiological differences between attempted suicide and completed suicide populations. Most researchers have subsequently maintained the distinction between the two types of behaviour. (There are, of course, some exceptions: see Koller and Cotgrove, 1976; Lester, 1970, 1972; Farmer, 1980.) There is abundant empirical evidence of epidemiological differences between suicide and

parasuicide populations (see, e.g. Kreitman, 1972, 1981; Ovenstone, 1973; Dorpat and Ripley, 1967; Wilkins, 1967; Kennedy et al., 1974; Shneidman and Farberow, 1961; Schmid and van Arsdol, 1955) but less widespread consensus on the extent to which the two behaviour types are differentiated on non-epidemiological variables. However, research evidence is available which suggests characteristic differences in relation to the methods of self-harm which have been used, clincial aspects (e.g. psychiatric diagnosis, personality diagnosis, previous psychiatric treatment and physical illness), psychological features and personality patterns. (For useful summaries of these differences, see Kreitman, 1973, 1981; Kreitman and Dyer, 1980).

Although these appear to be reasonable grounds for demarcating non-fatal deliberate self-harm as a separate behavioural domain, worthy of investigation in its own right, a number of points still require clarification. In the first place, since "parasuicide" continues to be misunderstood (e.g. Adam et al., 1980), it is necessary to emphasise the purely descriptive nature of the term. It does not refer to behaviour which is "merely" a "gesture" or "manipulation" or "attention seeking", rather than truly suicidal. Likewise, it takes nothing for granted about the extent or even presence of suicidal intent. Thus "parasuicide" can refer to behaviour ranging from the medically inconsequential to the life-threatening; undertaken with no suicidal intent or a strong and univalent desire to meet death; planned rationally and in clear consciousness or dictated by the symptoms of a severe psychotic depressive illness. It is an umbrella term, a rubric which covers a heterogeneous collection of behaviours which share one minimal attribute, namely, that they are deliberately performed and intended

to cause harm to the individual. The "meaning", perception and definition of "parasuicide" (whether from the point of view of the actor, the actor's significant others, or agencies of the state) are thus not taken-for-granted elements, but open to empirical investigation and assessment. They are thoroughly explored in the present work.

The second important issue relates to the paucity of interest shown by sociologists in parasuicide. Not only have they failed to carry out empirical research into the phenomenon (a not unexpected finding, given the profession's preference - in the case of suicide - for studying statistics rather than victims), but they have also ignored conceptual and theoretical issues which have proved so irresistible when doing sociological work on suicide. In other words, there is no extant corpus of theory and data which merits the honorific appelation "sociology of parasuicide". In the development of methods and ideas relevant to the investigation reported in this thesis, I was therefore forced to consider the extensive non-sociological literature on parasuicide and also mainstream sociological writing on suicide. I assume that no justification is required for a wide-ranging pursuit of relevant empirical material on parasuicide undertaken from an epidemiological or psychiatric or psychological viewpoint. On the other hand, I feel that some defence is necessary to support my use of data and theory relating to completed suicide.

I have drawn attention to the usefulness and validity of the analytic distinction between suicide and parasuicide. However, empirical evidence supports the contention that while the two populations tend to have different characteristics, there is also a

considerable degree of inter-connectedness between them: they are "two separate, but overlapping, populations" (Freeman et al, 1974: 19). As many as a third (Dorpat and Boswell, 1963) to a half (Ovenstone and Kreitman, 1974) of suicides have had a prior "attempt", while approximately 1% of parasuicides go on to commit suicide per annum of follow-up (see Kreitman, 1977: 165). Kreitman and colleagues themselves criticise Kessel's use of the term self-poisoning on the grounds that:

> "The omission of all references to suicide while historically understandable, neglects the very real association that exists between 'attempted suicide' and 'completed suicide'" (Kreitman et al., 1969: 747).

Conceptually, then, parasuicide is considered to be a "behavioural analogue" of suicide; it is a behaviour which mimics or simulates suicide. Empirically, there is a significant degree of relationship between parasuicide and suicide populations. It therefore seems reasonable to review the rich sociological literature on completed suicide, inasmuch as it provides data or theory relevant to the perspective adopted in this study.

That perspective is "cultural", in the sense that an explanation for the existence of a high incidence of parasuicide in certain geographical areas is sought in the subcultural meaning system held to prevail in such areas. In view of the problematic nature of the "culture" and "subculture" concepts, Chapter 2 is devoted to raising difficulties in meaning and measurement whose resolution is required to guide the development of an appropriate research design and methodology. A review of the literature on parasuicide and suicide

which has adopted a cultural perspective is provided in Chapter 3. The following three Chapters are concerned with the formulation proper of the investigation: hypotheses (Chapter 4), design and methods (Chapter 5) and Instruments (Chapter 6). The results of the investigation are presented in Chapters 7 and 8. Finally, the implications of the investigation are explored in Chapter 9 and 10: the former discusses the findings in some detail, while the latter outlines a number of suggestions for future research arising out of the present project.

Chapter 2 CULTURE AND SUBCULTURE: PROBLEMS OF MEANING AND PROBLEMS OF MEASUREMENT

2.1 Cultural structure and social structure differentiated

Sociologists have traditionally differentiated between the cultural and social aspects of human life, viewing them as analytically separable but mutually interdependent factors (Geertz, 1957; Vogt, 1960). Parsons and Shils (1951) distinguished between culture as an ordered system of meaning and symbols, in terms of which social interaction takes place, and social system as the pattern of social interaction itself. In culture we find a "framework of beliefs, expressive symbols, and values in terms of which individuals define their world, express their feelings, and make their judgments". In the social system we have "the ongoing process of interactive behaviour, whose persistent form we call social structure". (Geertz, 1957: 33). Similar distinctions are made by Kroeber and Parsons (1958) between "culture" and "society", and by Merton (1957) between "cultural structure" and "social structure". These are conceptualised as two separate systems only in as much as they abstract or select two analytically distinct sets of components from the same concrete phenomena (Geertz, 1957: 33-4). Clarke (1974: 428) puts it thus:

> "Although sociologists write at times as though social relations could be empirically carved up into culture and structure ..., these two concepts represent only an analytic distinction, that is they cover the same actual social relations from a different standpoint, selecting different aspects for consideration".

Clarke believes that the distinction between these complementary perspectives is hard to pin down, "but ultimately it probably consists in the concentration of culture on what people say and think, and of structure on what they do and what is done to them" (pp 428-9). The major focus of the structural perspective is the basic order of social relations and social events, while the orientation of the cultural perspective is towards an appreciation of meaning.

2.2 Elements of a cultural analysis

What is meant by "culture"? Two major conceptualisations of the term can be found in the literature. Most commonly, "culture" refers to the entire system of meanings of some population delimited by possession of a unique configuration or pattern of cultural meaning structures (e.g. ideologies, values, etc.), or by political boundaries, or by sociogeographic isolation (Radcliffe-Brown, 1957). Society is seen as the regularities of behaviour, the structure of social relations, the system of interpersonal relations, the configuration of social institutions.

> "Each more or less uniquely structured society is the organisational fabric upon which the uniquely patterned culture is an appliqué and by means of which it is passed on interpersonally through time." (Leeds, 1971: 228).

Merton (1957: 218) refers to culture as "the normative pattern". For Williams, it is to be conceived as a normative structure, a system of what Linton (1936) has called "designs for living":

"In this sense, culture is the 'blueprint for behaviour' - relatively standardised prescriptions as to what must be done, may be done, and must not be done." (Williams, 1960: 23)

According to Goodenough (1963: 259):

"Culture ... consists of standards for deciding what is, standards for deciding what can be, standards for deciding how one feels about it, standards for deciding what to do about it, and standards for deciding how to go about it."

In the other (less common) major conceptualisation of "culture", the term refers to the interwoven network not only of meanings and behaviours but also of social bodies and relationships characteristic of some population delimited by the unique configuration or pattern of such a network, by sociogeographic isolation, or by political boundaries. Such a population is usually referred to as a "culture" (e.g. Lewis, 1966a, 1966b). The difference between the two viewpoints lies in the fact that the latter incorporates "society" into the definition, effectively treating "culture" and "society" as homologous constructs, while the former excludes the actual population (or population segment) from the definition and treats it instead as the referent of the culture. It is this more restricted conceptualistion which is adopted in the present work: culture here is held to refer to a system of meanings only.

Of what, then, does this "system of meanings" consist? Williams (1960: 23-5) lists the main normative aspects of culture as knowledge, beliefs, technology, values and norms. While knowledge

and beliefs have to do with what exists, or is supposed to exist, values, on the other hand, are "conceptions of the desirable" which influence selective behaviour (Williams, 1960, 1968; Kluckhohn et al., 1951; Rokeach, 1973). Thus:

> "Values ... concern standards of desirability; they are couched in terms of good and bad, beautiful or ugly, pleasant or unpleasant, appropriate or inappropriate ... Values in the sense of standards are 'conceptions of the desirable'. They are criteria for deciding what we should want." (Williams, 1960: 24, 410)

> "A value is a conception, explicit or implicit, distinctive of an individual or characteristic of a group, of the desirable which influences the selection from available modes, means, and ends of action." (Kluckhohn et al., 1951: 395)

> "A value is an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence." (Rokeach, 1973: 5)

Bengtson and Lovejoy (1973) define values as "conceptions of the desirable - self sufficient ends which can be ordered and which serve as orientations to action" (p 882), and note four elements of this definition. Firstly, values are cognitions, i.e. conceptions or beliefs about the world. Secondly, values are distinguished from other cognitions by their evaluative character. They are positive or negative affective judgements about the desirability of objects or states in the social world. Thirdly, values are alternatives

implying action and choice. Finally, values refer to ultimate cognitions applied to desirable end-states of existence. They attach to recurrent, long-term problems in human functioning, rather than to immediate gratification of transitory need. Seen in these four ways, the value pattern of an individual represents the "background assumptions" (Gouldner, 1971) which the person uses in making difficult decisions about where to invest limited resources of time and energy throughout life. Value orientations is the term given to the most general, least articulated dimension of the value complex. Value orientations are our underlying assumptions and evaluations about our relationship to our environment - physical, temporal, social and spiritual. These broad attitudinal sets form the background from which more explicitly stated values derive.

Values and value orientations may be usefully classified in a large number of ways. Underpinning most classifications, however, is the recognition that value phenomena can be treated as both independent and dependent variables in social science analysis. On the one hand, values influence selective behaviour; they serve as criteria for selection in action.

> "When most explicit and fully conceptualised, values become criteria for judgment, preference, and choice." (Williams, 1968a:283)

On the other hand, values as empirical elements in human behaviour arise out of human experience and may be affected by any conditions that affect experience. As Williams (1967: 24) asks:

> "Indeed, where else [could they arise from]? ..... Values do

not suddenly emerge from nowhere as mysterious, self-generating uncaused causes in human life, but rather have sources and contexts."

Values arise out of an existential process of coping with situations in daily living. Some experiences relate to an individual's location in social structures: the objective conditions of his/her status produce a context in which conceptions of the desirable are formed. Other experience relates to the individual's idiosyncratic or idiographic adaptive response to events and conditions of life: the subjective reactions which are reflected in measures of psychological affect. Thus, as Bengtson and Lovejoy (1973) show, values/value orientations arise from, and covary with, both objective conditions of social location (the social system) and subjective conditions of affect (the personal system).

> Norms are another distinctive element of culture. They are "rules for behaving: they say more or less specifically what should be or should not be done by particular types of actors in given circumstances." (Williams, 1968a:284)

Values are closely related, conceptually and empirically, to norms, but norms are the more specific, concrete, situation-bound specifications: values are the criteria by which norms themselves may be and are judged. The same values may be a point of reference for many specific norms; and a particular norm may represent the simultaneous application of several separable values (Williams, 1968a:284). Dutta (1969) argues that while empirically values and norms are intricately intertwined by their impact on one another, in theory they are completely different categories of symbols directing action

(values being shaped primarily by religious experience and norms by the exigencies of organised activity). Bidwell (1966) points out that shared values may legitimate quite distinctive norms sets (what he calls "unitary legitimation"), while pluralistic values may also legitimate a single norm set ("pluralistic legitimation"). Rokeach summarises the major differences between values and norms, as usually conceptualised:

(1) a value may refer to a mode of behaviour or end-state of existence, whereas a social norm only refers to a mode of behaviour;

(2) a value transcends specific situations, whereas a social norm is a prescription or proscription to behave in a specific way in a specific situation;

(3) a value is more personal and internal, whereas a norm is consensual and external to a person (Rokeach, 1973: 19).

Behaviour itself should also be included as an element of culture. In certain segments of the society, verbal acceptance of idealised norms and values is often accompanied by behaviour which directly contradicts these ideals. Inasmuch as this behaviour is widespread and frequent, it has the potential of transmitting an image of itself to others:

> "In a most elementary sense, it is an act of cultural transmission - it is turned into such transmission, that is, if the potential recipient adds his image of the mode of action in question to his own cultural repertoire." (Hannerz, 1969: 185)

2.3 Subculture versus contraculture

Each modern Western industrialised society can be analysed as a

cultural whole; its general "meaning system" can be compared to that of other comparable societies. However, it is also the case that each such society is internally differentiated into numerous sub-groups, or sub-societies

> "each with ways of thinking and doing that are in some respects peculiarly its own, that one can acquire only by participating in these sub-groups and that one can scarcely help acquiring if he is a full-fledged participant." (Cohen, 1955: 12)

The normative systems of these sub-societies are referred to as subcultures or "cultures within the culture". Unfortunately, as many authors have noted, the subculture concept is used so widely and given so many different meanings, that its value is severely limited. Yinger (1960: 626-7) distinguishes between two usages of subculture which are commonly found in contemporary accounts.

> "The term is often used to point to the normative systems of groups smaller than a society, to give emphasis to the ways these groups differ in such things as language, values, religion, diet, and style of life from the larger society of which they are a part ... This ... meaning ... must be distinguished from a [second] meaning associated with it when the reference is to norms that arise specifically from a frustrating situation or from conflict between a group and the larger society ... In addition to a cultural dimension, this ... usage introduces a social-psychological dimension, for there is direct reference to the personality factors involved in the development and maintenance of the norms."

Yinger proposes to replace the term subculture with the term "contraculture" when referring to a normative system characterised by the creation of inverse or counter values (opposed to those of the surrounding society) in the face of serious frustration or conflict. This useful analytic distinction will be followed in the present work. When we talk about a subculture, we have in mind an organised set of social meanings which bear some relationship to the larger, more inclusive set called "the culture" (Clarke, 1974). By definition, there must be a link at some level between the subculture and the dominant culture. If there is no link at all then we are dealing with a separate culture or a contraculture. Clearly, if we wish to test empirically the proposition that a subculture exists, then it would not be appropriate to seek out an oppositional meaning system which is characteristic of a contraculture. For a subculture is expected to differ from the dominant or parent culture in degree rather than in kind. The subculture/contraculture distinction therefore has far-reaching implications for the evaluation of evidence concerning differences between cultural groups.

2.4 Definition of subculture

For the purposes of the present investigation, subculture is defined as a patterned set of values, norms, beliefs and behaviours, shared by an identified group of individuals, and diffused by formal instruction or acquired in interaction with others. By "patterned set", we are referring to the fact that the various elements of the putative subculture should fit together into a coherent whole, a "blueprint" for living which has a degree of internal consistency and which can be differentiated (in some measure) from the parent culture and other subcultures. The definition also reminds us of the re-

quirement to assess all the major elements or features of the cultural system, both ideational and behavioural. This point bears emphasising in view of the fact that it is not unusual for "cultural analysis" to concern itself solely or predominantly with the assessment and measurement of values. For instance, Wolfgang and Ferracuti (1967) and Ball-Rokeach (1973) assume that values are the cornerstone of all explanations of subcultural modes of behaviour. Consequently, empirical tests of the subculture of violence hypothesis tend to rely on evidence of value differences between those who are and those who are not members of the putative subculture. However, while values are indeed cultural elements,

> "they do not exhaust cultural content. One must study the normative prescriptions and proscriptions found in any social group as well as common accepted behaviours. Norms and behaviours shape the dynamic of an ongoing cultural system as well as provide ways of doing things in everyday interaction. Finally, one must include the material elements or artifacts of a culture, including clothing, hairstyle, ritual objects, food, tools, and play objects. The complete picture ... consists of a range of components from the physical and visible (artifacts and behaviours) to the 'ideational' (values and norms)." (Fine and Kleinman, 1979: 7)

The importance of measuring norms and behaviour, as well as values, for a thorough delineation of culture is fully recognised by the present author. Although disagreeing with Blake and Davis' statement that "the best evidence of values is in the norms themselves", we can concur with their view that

"It is the norms, not the values, that have the pressure of reality upon them. It is the norms that are enforced by sanctions, that are subject to the necessity of action and the agony of decision. It is therefore the norms that represent the cutting edge of social control." (Blake and Davis, 1964: 460-1)

In the same way that we distinguish between society and culture, so we need to draw a distinction between subsociety and subculture. Some authors treat subculture as a subsociety, i.e. as a membership category, such as a gang or youth. However, we have rejected this approach and therefore need to determine the referent for the subculture, that is, "a clearly defined population which shares cultural knowledge" (Fine and Kleinman, 1979: 4). Fine and Kleinman (1979) draw attention to the fact that many studies of subculture do not explicitly delineate the population to which the concept refers, but assume that the relevant segment may be identified through demographic features. However, they believe that subculture must be tied to a more exact referent, namely a population characterised by "effective interaction". While such a viewpoint would be widely endorsed, the nature of meaning of "effective interaction" is variously interpreted. The symbolic interactionist perspective emphasises the importance of face-to-face interaction in the generation and activation of cultural elements (e.g. Becker et al, 1961). But how, ask Fine and Kleinman, is a culture spread through a society in which most members are not in face-to-face interaction?

We argue that although culture is meaningful only when it is activated in interaction, cultural elements may constitute a subculture through the diffusion of information among groups

.... Small groups are connected with other groups through a large number of interlocks, or social connections. These connections assume a variety of forms .... Through these communication interlocks, cultural information and behaviour options are diffused, resulting in the construction of a common universe of discourse throughout the social network in which they are spread. The social network serves as the referent of the subculture .... Subcultures, then, are conceived of as emanating from group cultures." (Fine and Kleinman, 1979: 8-9)

In their discussion of the types of communication interlocks, which make possible the spread of cultural items, Fine and Kleinman highlight multiple group membership, weak ties, structural roles and media diffusion. However, they do not elucidate the manner in which such diffusion takes place. Here, we can draw on a useful distinction made by Hannerz (1969) between a "hard" culture concept and a "soft" culture concept. The former refers to the explicit instruction given by members of a social group to others in the group (e.g. parents to children) about basic values, beliefs, aspirations and norms; while the latter refers to "the continuous community-based maintenance of ... cultural features in interaction idioms" (p 184). Hannerz illustrates the distinction by asking us to consider how we can decide what kinds of behaviour are culturally influenced. A hard culture concept directs us to note only the explicit instruction given by the older generation to the younger about its basic values and beliefs. On the other hand, a soft culture concept focusses upon cultural sharing where instruction is largely accidental but results instead from role modelling. A major difficulty associated with the more narrow hard culture concept is that it leads to the labelling of certain modes of behaviour as non-cultural. For if parents do not

invest a social act with sufficient normative significance to care to pass it on to their children, then by definition that act must be non-cultural. Thus the conceptualisation of suicidal behaviour as cultural would, in most cases, be ruled out a priori.

2.5 Subculture, class and behaviour

There has been a long-standing debate in sociology and anthropology about the relationship between behaviour and normative aspects of culture within and between social classes. While there is overwhelming evidence of differences in behaviour between social classes - for instance, in child-rearing patterns, use of leisure, interaction with kin and friends, crime, language, etc. - the extent to which such differences reflect contrasting weltanschauungen, meaning-systems or cultures is much disputed. One extreme position would claim that there is (or has to be) a common value system to which all segments of society adhere. At the other extreme lies the contention that society is based on a class-differentiated value system. In fact, a close reading of the literature suggests that even those most closely associated with the former position recognise the existence of subcultures and the plurality of modern industrial society. Thus, Parsons (1953), while emphasising that "it is a condition of the stability of social systems that there should be an integration of the value standards of the component units to constitute a 'common value system'" (p 93), also notes that the value system of ethnic groups may differ from the "paramount" value system of the dominant society. "Within certain limits of tolerance it may tend to form a variant subsociety within the larger society, more closely approximating implementation of its own values." (p 118) Merton (1957) believes that we can only speak of a human aggregate as

comprising a society "because behaviour is typically oriented toward the basic values of the society ..." (p 141). However, his reference to a "deposit" of values shared by interacting individuals implies that there may well be a variation in less fundamental values in different segments of the social structure. Shils (1961) draws attention to the fact that the "central value system" (i.e. "the values inherent in the standards of judgments and action, espoused and more or less observed by those in authority") is not the whole of the order of values and beliefs espoused and observed in the society.

> "The value systems obtaining in any diversified society may be regarded as being distributed along a range. There are variants of the central value system running from hyper-affirmation of certain of the components of the major central value system to an extreme denial of some of the major elements ..., which might be coupled with an affirmation of certain elements denied or subordinated in the central value system."

Likewise, those who conceptualise society as riven by class-differentiated value systems recognise that the normative order consists of a number of competing meaning-systems. Thus, Parkin (1971) suggests that there may co-exist "dominant", "subordinate" and "radical" value systems, at all levels of society, including among the subordinate class. The social source of the dominant value system is the major institutional order; dominant values represent the perceptions and interests of the relatively privileged. Yet, as Parkin points out, such values often form the basis of the moral judgement of underprivileged groups by virtue of the institutional backing they receive. Dominant values tend to set standards for what

is considered objectively "right".

Despite the fact that the polar positions on this issue are somewhat ideal-typical (rather than actively promoted by social scientists), they do manifestly carry different implications for the interpretation of the relationship between socioeconomic rank and behaviour. In particular, proponents of the two positions have argued heatedly about the status of "lower class culture": is it to be seen as an adaptation to situational constraints or as an autonomous cultural pattern in itself? And, more generally, the proposition that there are class subcultures has been subject to a variety of different responses.

One of the most useful contributions to the debate about these issues has been made by Kriesberg (1963, 1970), who distinguishes between subcultural and situational explanations of differences in behaviour between groups differing in socioeconomic status. A cultural explanation would direct attention to the parental transmission of values and behaviour patterns. The lower class, for instance, can be seen to possess a mutually consistent and supporting set of values, beliefs and patterns of conduct. This set of characteristics differs from that possessed by persons in other strata. They form a way of life appropriate to the problems the members face, which is acquired early in life and passed from one generation to another. A situational explanation, on the other hand, holds that there are no differences in values by socioeconomic rank; differences in behaviour result from differing opportunities. Two types of situational factors are distinguished: the social (e.g. patterns of interaction) and the non-social (e.g. financial resources).

Kriesberg's own preference for a situational explanation of lower class behaviour is shared by a number of authors. Phil Cohen (1972), for instance, discusses the particular subcultural pattern in working class East End London and concludes that this is a response to structural contradictions and conditions which cannot be overcome. Rainwater (1970) sees the distinctive lower class subculture as a created endeavour based on elements available in response to, firstly, given conditions, and, secondly, selective freedom. Gans (1968) considers that the behaviour of the poor results to a large extent from an adaptation to an existential situation. When the situation changes, the behaviour changes also. This view of a change in social situation leading to a change in behaviour is echoed by Leeds and Leeds (1970), Clarke (1974) and Yinger (1960), among others. Even Oscar Lewis, who is correctly savaged by numerous critics for his view of the culture of poverty as a self-perpetuating, structurally autonomous ordering of human life, recognises the adaptiveness of the behaviour of the poor (Lewis, 1968).

The situational approach either denies the existence of variation in values (and other normative elements) between social classes, or minimises the significance of such variation. If social classes differ in values, it is because the characteristic life situation in any class makes any given value relatively attainable/unattainable or relatively comprehensible/incomprehensible. Classes differ not so much in generating distinctive value systems, but more in the relative emphasis and the embodiment of their society's values, which derive from their distinctive life situations. Even Kriesberg (1963) acknowledges that lower-class values may differ from those of other groups, but maintains that this results from a common

exposure to stratum-shared current situations, rather than from the adoption of a radically different "blueprint for living" passed on intergenerationally. According to Kriesberg, shared values and beliefs which arise out of accommodation to current behaviour or out of current social pressures are to be distinguished from those which are cultural, i.e., "transmitted through generations".

The subculture approach, on the other hand, assumes that each social class is to some degree a self-contained universe, developing a distinctive set of values which guide its members' way of life. The subcultures of different classes are in important respects held to be mutually contradictory. Thus, Kahl (1957: 10):

> "... [T]he people who perform the same activities or who occupy a given prestige level in a stratification system evolve a set of value orientations distinctive to themselves. Consequently, if we measure values, we measure stratification position."

Kohn (1963) believes that social class is such a useful concept because it refers to more than simply education level or occupation, etc. It also captures

> "the reality that the intricate interplay of all these variables creates different basic conditions of life at different levels of the social order. Members of different social classes, by virtue of enjoying (or suffering) different conditions of life, come to see the world differently - to develop different conceptions of social reality, different aspirations and hopes and fears, different conceptions of the desirable [values]." (p 471)

One well-known example of empirical research which is usually held to support the subculture approach is that provided by Hyman (1966). He allegedly presents empirical evidence to show that the lower class person's attitudes, values and aspirations differ from those of other classes. (However, his interpretation of the findings is open to the charge of extreme partiality). An equally famous theory of lower-class behaviour on subcultural lives is put forward by W.B. Miller (1958). He suggests that the cultural system which exerts the most on influence on "gang delinquency" is that of the lower-class community itself -

> "a long-established, distinctively patterned tradition with an integrity of its own .... There is a substantial segment of present-day American society whose way of life, values and characteristic patterns of behaviour are the product of a distinctive cultural system which may be termed 'lower class'." (pp. 5, 6)

To what extent are these competing explanations of the relationship between socioeconomic status and behaviour tenable or useful? In an unusually perceptive analysis of culture concepts, Hannerz (1969) points out that this dichotomy of tradition and adaptation, culture and situation is false. Whereas the situationists maintain that lower class culture (or the "culture of poverty") is largely an adaptation to the environment and not a cultural tradition, Hannerz states that all culture is largely situational.

> "In fact, it is only anthropological common sense that any culture is adapted to its environment - otherwise there would be nothing to call cultural ecology .... If in the case of the

ghetto dwellers, and the poor more generally, the constraining environment is social, rather than natural as in most traditional ecological studies in anthropology, it makes little or no difference in principle." (p 183)

I have already discussed Hannerz's soft culture concept with its emphasis upon accidental cultural transmission through role modelling, and his rejection of the hard culture concept which takes only explicit norms into account. Yet, as he points out, it makes little sense to view as cultural a mode of action which occurs in a community but which is regarded as totally illegitimate by its members. A person must be able to account for his behaviour in acceptable moral terms for it to qualify as cultural. Here Hannerz argues that the very occurrence of an act in a ghetto situation - regardless of its officially deviant or illegal status - can be taken to indicate that at least the actor involved regards it as an appropriate mode of behaviour. The more often the behaviour occurs the greater the individual's readiness to find it not only convenient but also morally appropriate. Inasmuch as ghetto dwellers also hold mainstream modes of behaviour to be legitimate, then ghetto culture can be said to contain a range of alternatives.

At this point, Hannerz, in common with numerous others writing on this topic, pays tribute to Rodman's seminal work on the lower-class value stretch. By the introduction of this concept, Rodman (1963) hoped to resolve some of the contradictions between the common value system and class-differentiated value system positions, and provide a better understanding of lower-class behaviour. After reviewing these apparent contradictions, Rodman focuses upon the reactions of lower-class individuals to their deprived circumstances.

"By the value stretch I mean that the lower-class person, without abandoning the general values of the society, develops an alternative set of values. Without abandoning the values placed upon success ..., he stretches the values so that lesser degrees of success also become desirable .... The result is that the lower-class, in many areas, have a wider range of values than others within the society. They share the general values of the society with members of other classes, but in addition they have stretched these values, or developed alternative values, which help them to adjust to their deprived circumstances." (p 209)

Rodman notes that if he is correct that the predominant lower-class response to its situation is the value stretch, then the contradictions between the two positions are more apparent than real. Lower-class members do share the values of other social classes in the society and also hold values which are unique to themselves. The positions are "both correct, both incomplete, and complementary to one another". (p 210) Equally importantly for the present investigation, the notion of the value-stretch does not undermine the conceptualisation of social classes as subcultures, although it does cast serious doubt on the extreme position that different social classes constitute contracultures. Differences in degree (relative) between social class groupings are more to be expected than differences in kind (absolute), and are perfectly compatible with a subcultural approach.

2.6 The delineation of subculture

Much controversy surrounds the question of the appropriate

methodology for investigating the content of a subculture and its referent. A typical approach taken by more positivistic sociologists to the delineation of the subculture of violence, for example, has been to study the set of central or core values held by a population sample by means of standard survey techniques (Ball-Rokeach, 1973; Erlanger, 1974). Survey research has also been used to describe youth subcultures, inmate subcultures, etc. A contrasting approach is that taken by Lewis, who utilises more traditional ethnographic methods in the mainstream of cultural anthropology (e.g. Lewis, 1966a, 1966b). Fine and Kleinman (1979) hold strong, unambiguous views on this matter:

> "Neither of the two major empirical approaches to the study of subcultures - case studies and survey research - provides adequate operationalizations of the subcultural referent." (p 4)

In view of our reliance upon survey-type methodology, we shall critically examine the problems with this type of approach, as described by Fine and Kleinman. Firstly, they allege that it is an insensitive research procedure "because it assumes that individuals who share the content of the subculture will be willing to reveal their attitudes to an interviewer. This is particularly relevant when the interviewer is not identified with that subculture and produces a devastating effect when the subculture has values which conflict with those of the individual's culture." (p 5) Secondly, they are critical of the assumption that there will be large numbers of respondents who share the subculture in the particular demographic segment of the population sampled. Thirdly, the convention of exploring subculture by collecting only publicly expressed value statements is inadequate, because particularly distinctive elements,

such as customs, behaviours and shared understandings, are overlooked. "These elements should be included, but it is difficult to collect data on them through survey techniques " (p 5). Fourthly, the subculture must be tied to a more exact referent than a population identified by standard demographic variables. The referent should be characterised by "effective interaction". Finally, the presence of a subculture cannot be inferred from relative agreement on a set of attitudes, behaviours, values, etc. The researcher must also show that "(1) communication occurs within the population segment, and (2) members of the population segment define themselves as a group, that is, share common identification " (p 5).

I have no disagreement with the fourth and fifth points made by Fine and Kleinman. I shall consider below whether available evidence (survey and ethnographic) supports the contention that there is indeed a subculture present in a particular area of Edinburgh, using these criteria. However, I am not convinced by the allegation that the survey approach is inherently insensitive. In fact, it is arguable that the more impersonal the method of data-collection, the more the informant will be willing to reveal strongly held and idiosyncratic feelings and attitudes. I know of no firm evidence which points to the superiority of any one particular approach to collecting such subjective data. On the second point, it is surely a matter amenable to empirical scrutiny whether the subculture is shared by a large or small number of respondents in a sample. Furthermore, the number of individuals who might be considered to be the referent for the subculture in the whole population can also be calculated. Finally, I have already expressed my agreement with the view that cultural elements include more than a set of core central values, and that customs, behaviours, norms, etc. must also be

studied. However, while it may be difficult to collect such data by means of survey techniques, it is by no means impossible. This point is taken up in considerable detail in Chapter 6.

Chapter 3 TOWARDS A "CULTURAL" PERSPECTIVE ON SUICIDAL BEHAVIOUR: A REVIEW OF THE LITERATURE

3.1 The structural perspective in suicidology

The conventional approach in sociology to the study of suicidal behaviour dating back to the Durkheimian era (e.g. Durkheim, 1897 (1952); Masaryk, 1881 (1970)) has been structural, in terms of its identification of both the basic "problem" to be solved and of the key independent variables likely to have explanatory and heuristic value. In Durkheim's view, the central concern for sociologists studying the problem of suicide was the explanation of variation in suicide rates between and within societies. He also postulated that a suicide rate in some way reflects the quality of social relations in a population (Durkheim, 1952: 209). This twin emphasis upon variation in rates as the dependent variable and disturbed social relationships as the major independent variable has been shared by a number of major authors. Gibbs (1971), for instance, noting that "sociologists have tended to follow Durkheim's lead in considering variation in suicide rates as the major problem" (p 284), emphasises that the foremost task of sociological studies of suicides is to explain differences in rates. "A general theory of the incidence of suicide must account for variation among all types of population." (p 286). The focus upon a structural explanation of suicide, found pre-eminently in the work of Durkheim, is echoed by later theorists. Thus, the first postulate of Gibbs and Martin's theory of status integration and suicide states that "The suicide rate of a population varies inversely with the stability and durability of social relationships within that population." (Gibbs and Martin, 1964: 27).

One of three basic postulates in Henry and Short's general theory states that the suicide rate of a population varies inversely with the strength of the relational system of the members (Henry and Short, 1954). Halbwachs (1930 (1978)) put forward the view that suicide rates among populations vary directly with the degree of social isolation. Gibbs (1968a) notes that "[a]lthough seemingly divergent concepts are employed in statements of the[se] theories, the central notion in most of them is that a suicide rate somehow reflects the quality of social relations in a population." (p 27). In fact, Gibbs (1968a) attempts to formulate an "integrating thesis" ... "by postulating disruptions of social relations as the etiological factor in suicide. The general thesis is stated formally as two propositions: (1) the greater the incidence of disrupted social relations in a population, the higher the suicide rate of that population; and (2) all suicide victims have experienced a set of disrupted social relations that is not found in the history of non-victims." (p 17: emphasis in original).

3.2 The phenomenological critique

The Durkheimian paradigm, although dominant for the past century, has not received unanimous endorsement. The most fundamental attack upon its positivist assumptions has been mounted by phenomenologically oriented sociologists (e.g. Douglas, 1966, 1967; Atkinson, 1968, 1971, 1978; Henslin and Campbell, 1974), who explicitly reject the attempts of Durkheim and his school to reduce social life to variables and their relationships, i.e. his treatment of suicide rates as an objective social fact to be examined in terms of associated social facts, such as degree of social integration. In particular, they argue that the manner in which suicide rates are

generated must constitute the major object inquiry, since "rates themselves are the products of social processess." (Atkinson, 1971: 166). According to this view, it is mistaken to believe that we need only improve our methods of collecting suicide statistics in order to get at some "real" rate of suicide, as though this had some concrete existence in an external world and was the product of a number of inter-related structural variables. Rather, it is necessary to examine the social meanings of suicide and the routine practices by which such meanings are enforced (Walsh, 1972). Thus, according to Douglas (1967), "there does not exist such a thing as a 'real suicide rate'" (p 196, n 40). An objective categorisation of suicides is impossible since suicide is not, as Durkheim assumes, a constant and unidimensional phenomenon. On the contrary, the meanings associated with suicidal behaviour vary both within and between cultures. These meanings will have a profound effect upon the official interpretations of "suicide". Douglas argues that the sociologist's first task is to examine the different forms of behaviour which a society labels "suicide" (the 'situated' or 'concrete' meanings of suicidal actions) in order to develop a classification of the different meanings associated with superficially similar forms of behaviour ("general dimensions" or "patterns" of meanings) (Douglas, 1966, 1967).

Douglas's emphasis upon the search for meaning is viewed sympathetically by a number of authors, even though they do not wholeheartedly share his reasoning or proposals for the direction future research should take. Thus, Baechler, rejecting the idea that suicide always has the same meaning, distinguishes eleven typically distinct situations where suicidal actions can be considered an adequate solution to an existential problem. These typical meanings

are flight, grief, punishment, vengeance, crime, blackmail, appeal, sacrifice, transfiguration, ordeal, game; they can be subsumed into four more general types: escapist, aggressive, oblative and ludic (Baechler, 1979). Douglas himself claims that a survey of literature in the West on suicide reveals a number of frequent patterns of meanings distinctive of suicidal actions, including atonement, revenge, escape, sacrifice, blame, self-punishment, the search for help and expiation (Douglas, 1967: 284-319). Taylor argues that "most suicidal acts may be usefully likened to an ordeal, a gamble with death and that one meaning of such action is the desire to renew life" (Taylor, 1978a: 385, emphasis in original; see also Taylor, 1978b, 1982). Urban, in a paper which predates the publication of Douglas' book by five years but appears to have gone largely unnoticed, noted that suicide can have a multiplicity of meanings including rest, escape, expression of hostility towards others, attempt to make others recognise one's feelings and wishes, thwarting of external forces and communication of feelings of discontent and anger (especially in "suicide attempts") (Urban, 1962). Atkinson (1971) investigates the role of coroners in the process of death registration on the grounds that data obtained from this source are of central significance in examining the social meanings of suicide. Even materialistic epidemiologists such as Hopper and Guttmacher (1979) pay lip service to the "essentially problematic ... meaning of suicide". (1979, p 434; emphasis in original). Henslin and Campbell (1974) summarise the position of those sociologists who have identified the "meaning" of suicidal actions as the central issue in this area of research:

> "... it appears to us that one cannot adequately understand suicide apart from understanding meanings - meanings for the

individual who commits suicide, meanings for the coroner or other officials who decide whether a death is a "suicide", as well as meanings for the survivors. In order to do this, we need much greater research on cultural, subcultural and personalistic or individuated influences on the meaning phenomena associated with death or suicide." (p 180)

3.3 Positivism and the "cultural matrix" of suicide

Durkheimian "variable analysis" (the term is taken from Blumer, 1967) does not, of course, necessarily deny the meaningful character of social phenomena. Actors' meanings are not ignored but treated as variables themselves, such as cultural prescriptions, role expectations, norms, values, etc. Even Durkheim himself, despite intentions and protestations to the contrary, provides social meaning to account for his findings, especially anomalous associations such as the high degree of education and low rate of suicide among the Jews (Durkheim, 1952 (1897): 166-8). However, meaning is typically treated as an intervening variable with the "ultimate" explanatory variables describing the morphological structure of society (Pope, 1976; Walsh, 1972). Thus, although Zeitlin (1968) believes that Durkheim's use of "socio-cultural variables to explain an ostensibly idiosyncratic phenomenon such as suicide must be regarded as ingenious and brilliant" (p 271), it is only in a limited sense that Durkheim can be said to be offering a "cultural" explanation of suicide at all. By contrast, later exponents of the positivistic approach have emphasised the desirability of including cultural factors in their explanatory accounts.

"Suicide is strongly influenced in form, meaning and frequency

by the culture in which it occurs. In order fully to understand the self-destruction of any individual, it is necessary to know the cultural matrix within which it occurs." (Reynolds et al, 1975: 35)

"The person contemplating suicide, the recovered survivor of a suicide attempt, the family members of a publicized suicide, and the volunteers and professionals at a suicide prevention center ... are functioning in a society that has established norms regarding the meaning of the act of suicide and the act of attempted suicide; with varying degrees of success they have been socialized to live in this society. The study, treatment and effects at prevention of suicide inevitably take place within a cultural milieu. These statements, albeit truisms and platitudes, are nonetheless relatively ignored." (Kalish et al., 1974: 301)

Farber (1968) goes even further in his "psychocultural hypothesis".

"[Suicide] has roots in the culture in which it occurs. Different suicide rates in different cultures are not haphazard. Rather they reflect suicide - producing forces in the culture which will be manifested in a number of different facts of the culture .... In short, suicide rates are an expression of the cultures in which they occur." (p 5)

Nevertheless, nowhere in the literature on suicide (and, a fortiori, on parasuicide) is there a serious attempt to delineate the essential ingredients of a cultural explanation. Major unanswered questions include: How do we describe and measure the

"cultural matrix"? In what way is suicidal behaviour an "expression" of the culture? How do we know how suicide is regarded in a culture? For all their interest in "meaning", phenomenologists and ethnomethologists have failed to clarify the manner in which suicidal behaviour reflects or articulates the culture in which it occurs. Other sociologists and anthropologists working in this area of research have tended to concentrate their efforts upon an examination of the relationship between the frequency/incidence of suicide and attitudes or normative orientations towards suicide. There is little evidence of interest in relating suicide to the value level of culture, or in examining the problems of the definition or perception of suicidal acts, or in encompassing actual behaviour as an element of culture. Even the narrowly focussed cultural perspective that predominates in the literature relies heavily, as we shall see, on the naive assumption of a "fit" between norms and behaviours. In the rest of the chapter this literature will be subjected to a critical scrutiny and crucial omissions in our knowledge of the influence of cultural processes on suicidal behaviour will be highlighted.

3.4 The "societal reaction" perspective

3.4.1 Development

The most general "cultural" explanation of variation in rates of suicidal behaviour between and within cultures posits a link between the normative evaluation of the behaviour in the culture or subculture, on the one hand, and its frequency or incidence, on the other. One of the earliest formulations of this proposition is found in Stearns (1921):

"Why do not certain forlorn, sick, and friendless ones end it all? Undoubtedly the pressure of public opinion, as expressed by law and church restriction, has had a restraining influence .... A hundred years ago, such sermons as Suicide: An Atrocious Offence Against God and Man .... were thundered from the Protestant pulpit; now many clergyman secretly condone the act. From this it would appear that change of custom is represented by an increased suicide rate. Public health measures framed to reduce this cause of death must, therefore, either restore the public opinion that acted as a check on suicide or find a substitute." (p 755)

Only a few years later, Cavan (1928) is claiming that the historical literature shows "that when attitudes exist which make suicide extremely distasteful, suicides occur infrequently ..." (p 56). She illustrates her argument with the following kinds of examples:

"... the dependence of suicide upon attitudes regarding it [i.e. suicide] are clear. When death was regarded as a natural event leading to a desirable phase of life [e.g. in ancient Greece and Rome] ... suicide was easily justified. The Christian attitude that life belongs to a superhuman power and that death may lead to suffering made suicide repulsive and almost non-existent." (p 24)

"One, perhaps the minor, deterrent to suicide among preliterates lies in certain adverse attitudes toward suicide held by many of these groups." (p 67)

The earliest formal statement of the hypothesis that completed

suicide is more common where societal condemnation is low is to be found in the work of Dublin and Bunzel (1933):

> "Where custom and tradition accept or condone it, many persons will take their own lives; where it is sternly condemned by the rule of Church and State, suicide will be an unusual occurrence." (p 15)

In similar vein, Farber (1968) maintains that the probability of an individual committing suicide is partly a function of the degree of toleration of suicide in the society: the greater the degree of toleration, the greater the relative risk of suicide (ceteris paribus).

It is interesting to note that more than fifty years after the proposition was first made, Lester (1972) can state quite accurately that the link between societal condemnation of suicide and its occurrence "has not yet been adequately tested". Writing at the same time, Gibbs (1971) criticises sociologists for their unfortunate lack of concern with variation in societal reaction to suicide. "An adequate explanation of such variation is, of course, a sociological goal in itself, but it is doubly important because of a possible relationship between societal reaction and the incidence of suicide." (p 285). Elsewhere, Gibbs (1968a) concludes that the character of social reaction should be considered in attempting to formulate a theory of variation in the suicide rate. "It is difficult to see how the sharp differences in evaulations of suicide could fail to have some influence on incidence." (p 25). It is conceivable, he notes, that suicide can be explained without considering the normative evaluation of the act. On the other hand, variation in the normative

evaluation of suicide is one aspect of suicide. Not only does it require explanation, but "it could also be a crucial factor in the aetiology of suicide, particularly variation in the rate. In other words, the possibility should be entertained that some social units have very low suicide rates primarily because the act is subjected to severe social condemnation in those units." (p 16). Despite his expression of these sentiments and his claim that the social reaction hypothesis has some empirical support (e.g. in Dublin and Bunzel, 1933), Gibbs nevertheless expresses doubts about its predictive power. For instance, he questions whether variation in reactions to suicide within a given society can account for differences in the suicide rate of various sections of the population. "There is no evidence that all increases or decreases in the suicide rates of countries reflect corresponding changes in the norms pertaining to suicide, and this would seem particularly true for the recent decrease of the rate in the United States" (Gibbs, 1971: 302).

Gibbs' doubts do not appear to be shared by other authors who concentrate upon cross-cultural, rather than intra-cultural, variation in suicide rates. Martin (1968), for instance, in his discussion of the societal reaction theory, leans heavily on Gibbs and also cites Dublin and Bunzel's study as providing some evidence to support the theory. However, close examination of Dublin and Bunzel's argument shows that, firstly, the thesis is presented as self-evident, as an <u>a priori</u> assumption and not as a testable proposition supported by empirical evidence; and, secondly, they themselves present data which cast doubt upon the validity of this assumption. They argue that they have "analysed historical ... data ... to discover the effect which the judgement of a community has upon the frequency of self-inflicted deaths" (p 15). They note the

striking differences in the frequency of suicide among primitive peoples: for some it is unknown and/or unthinkable, among other tribes it occurs occasionally and in others it is quite prevalent. Attitudes and moral judgements also vary greatly in different places: sometimes the act attracts neither praise nor blame, sometimes it is censured, sometimes it is considered an act of courage or honour. Dublin and Bunzel then link up these observations in a common-sensical way.

> "Obviously the very existence of a moral attitude, whether of approval or of condemnation, indicates that suicide is more or less common." (p 139: emphasis added)

This is not a deductive proposition but, as Martin (1968) has noted, an example of a would-be sociological truism, namely, norms and behaviour are correlated. But there is ample evidence that this truism has a shaky empirical foundation (see, e.g. Wicker, 1969). Finally, Dublin and Bunzel do not actually quote studies which have examined the frequency of suicidal behaviour and societal attitudes towards it in various tribes. However, some of their own observations contradict their central proposition. Thus, when referring to the Dakota Indians, they note in one place that suicide is "fairly frequent" among them, and in another place state that "[suicide] is thought to be displeasing to the Father of Life." (p 140). In fact, as we shall see, no truly empirical test of the hypothesis was undertaken until the 1970s.

3.4.2 Elements of the theory

The societal reaction theory depends upon three major elements. Firstly, that there exists variation in suicide rates between or within societies, at least sufficient to require some explanation. Secondly, that there is variation in the normative evaluation of suicidal behaviour. And, thirdly, that there is an association between the occurrence of suicidal behaviour and its normative evaluation. On the first point, it should be noted that the existence of variation in suicide rates is indeed questioned by those who, like Douglas, reject absolutely the notion of a "true suicide rate". However, Baechler (1979) is alone in arguing that suicide cannot be other than an inelastic phenomenon. "Suicide must be a universal constant." (p 29). He supports this statement by reference to the stability of suicide rates, citing the fact that rates only vary between 10 and 40 per 100,000 in most countries where there are reliable statistics. Most sociologists would, however, consider that the difference in suicide rates between Hungary (40.3 per 100,000) and Greece (2.8 per 100,000) (see Office of Health Economics, 1981: 14), or the 34% fall in the suicide rate in England and Wales between 1963 and 1970, were evidence of the variability and elasticity of suicide. After all, the declining rate in England and Wales did represent a saving of over 6,700 lives over the period as a whole (Office of Health Economics, 1981: 13; Sainsbury et al., 1980). The present thesis is based on an assumption that the seven-fold difference in parasuicide rates between high- and low-rate areas of Edinburgh constitutes a substantive finding that requires explication.

The second major element of the societal reaction theory is

variability in the normative evaluation of suicidal behaviour. Durkheim would have found it extremely difficult to accept that the normative status of suicidal behaviour might be variable or ambiguous. For Durkheim there could be no question but that suicide was immoral. This was his own personal belief, which he made abundantly clear in various passages (Durkheim, 1952): "Suicide must be classed among immoral acts ..." (p 337). "Since it offends morality, it should be repulsed more energetically and precisely, and this reprobation should be expressed by definite external signs, that is, penalties." (p 370). He also felt that the historical trend throughout the countries of the world was in the direction of a more absolutely condemnatory attitude towards suicide (pp 332-3). Although he was clearly worried that contemporary opinion was not as absolute and definite as he might wish ("opinion seems tending to become more indulgent on this point than formerly" (p 327)), he consoled himself thus: "If the public conscience seems less assured in its opinion of this matter today, ... this uncertainty may arise from fortuitions and passing causes; for it is wholly unlikely that moral evolution should so far reverse itself after having developed in a single direction for centuries." (p 333). Thirty-three years later, however, Halbwachs believed that while "common morality ... is hostile to it [i.e. suicide]", nevertheless "it is excused, accepted, found legitimate and even necessary in certain cases. Reactions will differ, depending on whether the suicide concerns a friend or a stranger, the head of a family, a bachelor, an elderly man, an ill one, or whether the misfortune is of some particular nature, such as ruination, dishonour, grief, etc." (Halbwachs, 1978 (1930): 307). Had there been such a striking change in the evaluation of suicide in the intervening years, or was Durkheim's view of a relatively undifferentiated public opinion, tending towards

absolute condemnation of suicide, mythical and ahistorical?

A review of the historical, philosophical, anthropological and sociological literature on this topic leads to the conclusion that Durkheim was projecting on to "society" his own strongly held views on the matter. (For a similar view, see Walsh, 1972: 45.) Abundant evidence exists of wide variations in normative evaluations of suicidal behaviour intraculturally, cross-culturally and over time. There is no space here to review these studies, but useful reviews of historical trends can be found in Macdonald (1977), Rosen (1971), Gibbs (1971, 1968a), Lecky (1955), Farberow (1975a), Porterfield (1968) and Dublin and Bunzel (1933). For discussions of cross-cultural differences in evaluations of suicide, see, e.g. Farberow (1975b), Steinmetz (1894), Dublin and Bunzel (1933), Stengel (1964), Bohannan (1960), Atkinson (1978) and Douglas (1967). Intracultural variation in evaluations of suicidal behaviour are also reported by a number of authors who clearly reject the notion of an undifferentiated conception of suicide within a particular culture (see, e.g. La Fontaine (1975), Firth (1961), Douglas (1967), Atkinson (1968), Halbwachs (1978), Hassan (1980) and Bayet (1922).

The most impressive documentation of these intracultural differences appears in Bayet's monumental study of moral attitudes to suicide in France, in which he differentiates "une morale simple" from "une morale nuancée".

> "Il n'y a pas, dans la morale contemporaire, comme on le dit trop souvent, une doctrine qui condamne le suicide et une doctrine qui l'approuve: il y a une morale simple qui condamne tous les suicides, en principe et dans tous les cas, et une

morale nuancée qui, plus souple, distingue entre les cas et va de l'horreur au blâme et à la désapprobation, de la désapprobation à la pitié, de la pitié à l'excuse, à l'approbation, à l'admiration." (Bayet, 1922: 23).

According to Bayet, the two doctrines divide the whole world of thought, teaching, the press, etc.

"[A] chaque etape de notre histoire, la morale nuancée triomphe avec les élites, avec la culture et la liberté; la morale simple triomphe avec la babarie, l'ignorance et la servitude." (Bayet, 1922: 800).

In general, "morale simple" is more powerful in the countryside, and in the popular milieux, while "morale nuancée" is found more often in the cultivated milieux (p 92). Unlike Durkheim, Bayet sees no natural evolution but more of a dialectical struggle between two opposed moralities.

Moving on over fifty years from Bayet's study, what is the evidence concerning differentiation of normative evaluations in contemporary Europe and the United States? According to Binstock (1974), suicide appears to be

"a relatively 'normal' condition of social life ...; hence, it is one alternative among many offered by the natural process of our social order. This does not suggest that the general public considers it as a realistic solution to individual or social problems, but even without considering it acceptable, our mass society has shown distinct signs of toleration and/or

indifference to those who wish to exercise this option ... We are coming to see suicide as less condemnable than it once was, increasingly understandable and preferable to aggression." (pp 68, 70).

Douglas (1967) shares these views. He finds little evidence of any general negative moral attitude towards suicide when actual cases of suicide are observed. If individuals are asked about what they think of suicide in the abstract, then a high percentage think it is in some way wrong. However, rarely are any moral judgements made about actual cases. They may be seen to be foolish, irrational, or senseless, but little moral feeling is involved. "Today, with probably only minor exceptions, people judge suicide in terms of the situation in which it is committed, and these situations rarely lead actual observers to condemn it morally." (p 44). Gibbs (1968a), however, is not so dogmatically sure, believing that the normative evaluation of suicide in the United States and other urbanised societies is "now uncertain":

"Generally, suicide appears to be still socially disapproved, or at least viewed as undesirable; but the normative evaluation is neither uniform nor categorical."

In some circumstances, for certain persons in certain statuses, suicide is prescribed or expected or approved. Suicide may also be disapproved regardless of the circumstances or status of the victim, but without overt institutionalised expression of the disapproval. Public opinion, he concludes, is divided, but not sharply because so many individuals have a clearly ambivalent attitude. La Fontaine (1975) notes that "contrary to popular belief, similar attitudes to

suicide may not prevail in all sections of society."

What is striking about the type of comments quoted above is not only that there is considerable disagreement between experts, but also how little empirical support is offered for the pronouncements that are made ex cathedra. Douglas (1967), for instance, argues that the first task in studying suicide must be to examine the different forms of behaviour which a society labels "suicide" in order to develop a classification of the different meanings associated with what superficially appear to be similar forms of behaviour. However as Atkinson (1978), Maris (1975) and others have pointed out, Douglas does not attempt to carry out research to discover how suicides become identified and categorised as such. Instead, he takes a sample of cases gathered and labelled suicides by psychiatrists and proceeds to construct his meaning types by abstracting from these cases. Likewise, Baechler's (1979) "suicides" (plural) are based on second-hand accounts of predefined "suicides" taken from the psychiatric literature. Atkinson, despite his doubts concerning the validity of using a particular cultural manifestation (play, religious practice, etc.) as evidence of the cultural significance of suicide (Atkinson, 1975), nevertheless goes on to employ newspaper accounts and observation of coroners' courts to establish the process by which a member arrives at a definition of suicide (Atkinson, 1978). However, there are some empirical studies on the meaning/ evaluation/definition of suicidal behaviour which include interviews with parasuicides, doctors, nurses, the lay public, etc., to ascertain members' own views.

Although virtually all this literature concerns parasuicide, there have been a number of studies of community conceptions and

attitudes about suicidal behaviour. Ginsburg's random sample of 208 subjects in Reno, Nevada, showed that there were different conceptions about the reasons for suicide. When respondents were asked why people in general commit suicide, very few mentioned intention. Suicidal acts were seen to happen to a person; they were not conceived as events a person intentionally brings about. When asked about the reasons why a particular person they knew personally had committed suicide, there was more emphasis on intention, and on external and interpersonal factors, and less on mood states. Over half the sample had known personally at least one person who had committed suicide (Ginsburg, 1971).

Kalish, Reynolds and Farberow surveyed 434 black, Mexican and Japanese and European Americans in Los Angeles, asking them: (1) what were the main reasons for killing oneself; (2) what kind of individuals killed themselves; (3) how they felt about people who had threatened to kill themselves but did not "seem to be serious"; (4) about their contact with suicide, and (5) who they would go to for help with someone considering suicide? The author found significant differences on all items by level of education. Differences were also noted by ethnic group, age and sex (Reynolds et al., 1975; Kalish et al., 1974).

Johnson et al. (1980) studied public attitudes towards conditional suicide (i.e. suicide as a response to poor health) among 1530 white American respondents. A preliminary analysis of the results of the investigation revealed that acceptance of both suicide and euthanasia is highly conditional and limited to certain segments of the population. Whites, males, younger age groups and the more educated were found to be more likely to support the notion of

suicide and euthanasia than blacks, females, older age groups and the less educated.

Boldt (1982) looked at selected aspects of the normative evaluation of suicide and death by means of interviews with a sample of 114 residents in a Canadian city drawn equally from two intra-familial generations. The findings lent support to the hypothesis that the younger generation holds more "accepting" attitudes towards suicide and death than the parental generation.

Finally, in this area of empirical research on the evaluation of suicide, Domino and colleagues have carried out a series of studies on a heterogeneous non-random sample of Americans (Domino et al., 1982), on students (Domino et al., 1980), on Christians and Jews (Domino et al., 1981), and on Mexican Americans and Anglos (Domino, n.d.), using a new instrument (the Suicide Opinion Questionnaire) designed to elicit opinions, feelings and factual knowledge about suicide. They found that over a third of the 100 items were rated significantly differently by Christians and Jews, and by Mexican Americans and Anglos. The survey of 800 college students showed a wide heterogeneity of attitudes, with 87 out of 100 items having at least one endorsement of each of the five response options. On thirteen items there was a bimodal response, and on only half the items was there a substantial consensus. Evidence that a "suicide attempt" is seen as attention-seeking or as a "cry for help" emerges from the study. The factor analysis of a heterogeneous sample of 285 questionnaires produced fifteen factors accounting for over three-quarters of the variance. Domino et al. conclude that the "overall results suggest that attitudes toward suicide are a rather complex phenomenon requiring a more sophisticated approach than simply a

positive vs. negative analysis" (Domino et al., 1982: 258).

The empirical literature describing variations in the normative evaluation of parasuicide is considerably more extensive and somewhat more sophisticated than the parallel literature on completed suicide. Some pioneering work has been carried out by Bancroft, Hawton and colleagues at Oxford on attitudes towards, and motivation for, parasuicide among parasuicide patients (Bancroft et al., 1976, 1979), psychiatric patients (Hawton et al., 1978), medical staff (Ramon et al., 1975; Ramon, 1980; Ramon and Breyter, 1978) and psychiatrists (Bancroft et al., 1979; Bancroft and Hawton, 1983). Among many other interesting findings, these investigations have revealed a striking disagreement between parasuicides and psychiatrists on motives for parasuicide. "Escape" and "loss of control", commonly chosen by patients, are rarely chosen by psychiatrists. Conversely, "communicating hostility" and "influencing others" are selected commonly by psychiatrists but rarely by patients. There were also notable differences between parasuicides and psychiatrists about whether the patient was seeking death. On the other hand, both groups were in agreement in rarely choosing "seeking help" as a motive for parasuicide. Ramon's study of nurses and doctors in different hospitals in Great Britain and Israel (Ramon and Breyter, 1978) revealed a pronounced similarity of selected motives across hospitals, cultures and professions.

Jeffery (1979) and Gibson (1977) carried out observation in casualty (accident and emergency) wards. "Overdoses", according to Jeffery, were one of the four major categories of "rubbish" recognised by casualty staff. The moral stigma, deviant status and low credibility attached to such patients was also found by Gibson.

Interestingly, she notes that the term "attempted suicide" was never used by staff to describe these patients. Goldney and Bottrill (1980) examined personal and professional attitudes towards attempted suicide and a number of other conditions among thirteen medical and paramedical occupational groups. Using a semantic differential scale, they found a considerable degree of nonsympathy towards attempted suicide, in fact significantly more than towards all other conditions except alcoholic liver disease (and ulcer and asthma to some extent). Barber et al. (1975) measured attitudes of fourth year students, final year students, house physicians and medical social workers towards self-poisoning patients compared to nine other "conditions". No differences in attitudes to any group were found among fourth year students and medical social workers, all expressed neutral or sympathetic views. Final year students and resident house physicians were more hostile to self-poisoning, alcoholism and juvenile delinquency. All groups agreed that the medical profession is more hostile to those three "conditions". The authors claim that after teaching and contact with self-poisoning patients the fourth year students' favourable attitudes to self-poisoning patients became even more pronounced. At the same time they became even firmer in their conviction that the medical profession has a highly unfavourable reaction to self-poisoning. Ghodse's survey of ambulance personnel and casualty staff attitudes in 62 London hospitals to patients who take overdoses (accidental, deliberate, and in the course of drug addiction) showed that deliberate overdose patients were regarded less favourably than accidental overdose patients. Overall, however, at least three-quarters of all the groups of staff interviewed had neutral or favourable attitudes to parasuicides (Ghodse, 1978). O'Brien and Stoll's survey of 60 members of staff of a central London hospital showed more "irritation" towards para-

suicides among sisters and housemen than among consultants and senior registrars (O'Brien and Stoll, 1977). The same findings of more hostility among junior medical and nursing staff than among consultants was also made by Patel (1975) in his survey of medical and nursing staff in hospital: half of the junior staff were "hostile" compared to a quarter of the senior medical staff. Patel found attitudes to parasuicides more hostile than towards eight other medical conditions. Milne (1977) also found strong disapproval of parasuicidal behaviour in her survey of medical staff in two hospitals in Fife, Scotland. Freeman et al. (1974) maintain that the typical attitudes of clinical staff to the "attempted suicide" patient are manifested in a "smug and not-too-subtle degradation". They refer to a number of studies which find that "clinical helpers often assume a pejorative attitude toward suicidal behaviour".

Finally, in an investigation which has a more direct bearing on the subculture of parasuicide hypothesis (see Chapter 4), Ansel and McGee (1971) set out to examine the attitudes towards "suicide attempters" in various helping groups and the lay public. They suggest that

> "A suicide attempter frequently creates negative attitudes in others, and thus the helper often responds to an attempter with hostility and rejection, perhaps failing to effect a change desired by the attempter, which was indeed the reason for the attempt. Such reactions may then prompt the attempter to engage in further suicidal behaviour." (p 22).

The subjects were psychiatric residents, psychiatric nurses, emergency room personnel, voluntary suicide crisis workers, police and

lay public in Florida. Their attitudes were measured by responses on semantic differential scales to twelve simulated case histories of attempted suicide, each varying in the degree of intention to die. They found that the majority of subjects in each group had scores indicative of negative attitudes to attempters in general. There were no significant differences between the groups. With only one exception, the attitudes of groups of helpers became more positive in relation to the degree of intention-to-die which they perceived in the case history description of the event. The greater the perceived intentionality of the patient, the more positive the expressed attitude towards the patient. (Interestingly, the exception was the group of psychiatric residents who were more negative with increasing intent to die.)

The third element in the societal reaction hypothesis is the association between the normative evaluation of suicidal behaviour and its occurrence. We have already seen that there are wide variations (intra-cultural, cross-cultural and historical) in both evaluation and occurrence, but it was noted that the association between them was based more on a sociological "truism" - namely, that individuals tend to conform to socially sanctioned demands and expectations - than on sound empirical evidence. I have only found two studies which have treated the proposition as a genuine empirical question. Sale et al. (1975) conducted a survey of 120 females aged 15 years and over living in two suburbs in Hobart, Tasmania. One suburb had the highest attempted suicide rate, the other the lowest rate (where, according to the authors, no cases of attempted suicide had been registered since monitoring of rates began in 1968). The hypothesis underlying their study was that the presence of sympathetic attitudes to suicidal behaviour will cause the

prospective attempter to anticipate desired changes and thus "select" such behaviour as a means of dealing with his/her problems (usually, interpersonal conflict). They expected, therefore, that high-risk populations for deliberate self-harm (DSH) would have more sympathetic or favourable attitudes to suicidal behaviour when compared to low-risk groups. It was suggested that a profitable approach to primary intervention might be to alter these subcultural attitudes to suicidal behaviour. However, the findings did not support the hypothesis. Using a Likert scale to measure attitudes towards suicidal behaviour along a hostility-sympathy dimension, they discovered that the low-rate suburb had a significantly more favourable view of DSH and suicide than the high-rate suburb, although both samples appeared to have relatively favourable and sympathetic attitudes. Attitude scale scores were unrelated to contact with completed suicide, but respondents who had contact with attempted suicide were more hostile and regarded "attempted suicide" as being "manipulative" rather than due to "mental illness". The authors speculate that the relationship between unfavourable attitudes and contact with attempted suicide may be due to negative attitudes promoting the occurrence of suicidal behaviour (as suggested by Ansel and McGee (1971)), or it may be that contact with attempted suicide has a tendency to change these attitudes in a negative direction. Sale et al. note the findings that para-suicides tend to be hostile and also to suffer hostility directed towards them by family members:

> "If this is the case, a high-risk population would be expected to have unfavourable or hostile attitudes and responses to alternative and less maladaptive forms of 'care-eliciting behaviour'. Persons in such an environment would thus find it necessary to

display more extreme forms of behaviour to elicit a satisfactory response from their significant others." (p 167).

Evaluation of this study is made somewhat difficult because, firstly, the various instruments are not described in full (not one item from the scale tapping attitudes to suicidal behaviour is presented); secondly, definitions of certain key terms (e.g. personal contact with suicidal behaviour) are not given; thirdly, a number of questions appear to be poorly worded; and finally, no details are given of the representativeness of the obtained samples.

The other relevant empirical investigation was carried out by Abbiati (1977), who attempted to operationalise Farber's theory of suicide (Farber, 1968). A questionnaire was devised which was intended to tap five proximal social psychological variables derived from Farber. The subjects were mature long-term residents of counties of Maine and Connecticut, that were characterised by relatively stable suicide rates. These counties were divided into a high rate area and a low rate area. Access to subjects (186 in the low rate area and 162 in the high rate area) was obtained through the churches in the target towns within the major areas. Local ministers were asked to compose a list of individuals from the general population (i.e. from within and without the church community) meeting the age (45 years plus) and residency (lived in the region continuously from early childhood) requirements. These criteria were supposed to ensure a population selection "that might conform to reasonable definitions of a culture or subculture" (p 84). Toleration of suicide (one of the five major variables) was assessed by scoring responses to a single question. As predicted by Farber's theory, low rate area residents were significantly less tolerant than their high

rate area counter-parts. Unlike the study by Sale et al., this is not worthy of serious consideration. Among its deficiencies are the criteria used to select subjects (which do not constitute an adequate definition of the subculture referent), the use of a single question to tap a major variable, the lack of evidence on psychometric properties of the instrument, and a failure to demonstrate the magnitude of differences in suicide rates between low and high rate areas.

3.5 The development of a broader cultural perspective

Although the survey by Sale et al. remains the only formal attempt (known to me, at any rate) to test empirically the link between subcultural attitudes and parasuicide rates, a number of other empirical studies, relevant to the development of a broader cultural perspective, should be considered here. The seminal paper is by Buglass et al., 1970. Buglass and her colleagues in the Medical Research Council Unit for Epidemiological Studies in Psychiatry had noted that there was a consistent pattern of differential parasuicide rates by city ward in Edinburgh. The areas of the city (wards) where parasuicide rates tended to be highest were characterised by economic deprivation (high unemployment, overcrowding, low rateable value, families more often receiving clothing grants and free school meals), deviance and law-breaking and child-related problems (truancy, referrals to Reporter of Children's Hearings, RSSPCC referrals) (Kreitman, 1977: 55-58; Buglass et al., 1980; Buglass and Duffy, 1978; see also, Philip and McCulloch, 1966). A study was consequently undertaken to determine whether the diffences in rates could be explained as a reflection of other differences in certain social and demographic characteristics of the

area populations. They set themselves to answer the question: If the population in all areas (wards) of the city had a similar distribution for each of several variables known to be related to parasuicide, would the parasuicide rate be the same in all areas? If the answer were "yes", then the excess of parasuicides in some areas would be "explained". If "no", and area differences still persisted, then there must be other factors which are more relevant. The six variables they chose were: age, sex, marital status, overcrowding, unemployment and social class. Simultaneous standardisation of the ward populations on age and sex did not reduce the variance of the morbidity ratio at all. Standardisation on all six variables reduced the variance by about two-thirds, but a statistically significant difference in parasuicide rates remained.

The authors emphasise that this is not a causative explanation.

> "It is not possible to say that the variables used in the standardisation procedure 'cause' parasuicide to a degree reflected in the reduction of inter-ward variation; they can be only indirectly related to 'causal' processes, the precise relationship remaining obscure." (Kreitman, 1977: 63)

They were merely able to say that two-thirds of the variance in ward parasuicide morbidity rates could be "accounted for" in a statistical sense. Their main conclusion was that "Residence in different city wards remains an interesting source of difference in the rates of suicidal behaviour". They noted that the inclusion of other variables might account for the remaining variation, and also pointed out that standardisation is dependent upon the way the variables are subdivided. Alternatively, they suggested that census-

type variables might themselves be inadequate to explain the area differences. Perhaps, they continue, the high rate of parasuicide and other deviant behaviours (e.g. completed suicide and child neglect) which are so prevalent in certain areas "have common roots in the attitudes, beliefs and values of the residents of these communities". Referring to the postulation by Wolfgang and Ferracutti (1967) of "subcultures of violence" where the resort to violence is more acceptable than in the society at large, Buglass and her colleagues go on to speculate thus:

> "It is probable that parasuicide, also, is more acceptable, as well as more common, in certain subcultural groups. In communities where impulsive behaviour takes precedence over long-term planning and where meaning is often communicated through action rather than by subtle verbal exchanges, parasuicidal behaviour would be expected to accord better with the overall life pattern. This is not to claim that parasuicide is normative in any culture, but it is suggested that for some groups the act represents less of a confrontation with accepted modes of behaviour and will invoke fewer sanctions than in groups where advance planning and verbal communiction is of greater importance. Both the salience of parasuicide as a behavioural option and the circumstances by which it may be triggered may be prescribed by the culture." (Kreitman, 1977: 63-64)

Two hypotheses are being suggested here: firstly, the incidence of parasuicide is related to its normative evaluation within a community; and, secondly, the incidence of parasuicide is related to certain elements or central tendencies in the community subculture or meaning system. Jointly, they came to be known (in the MRC Unit

where Buglass and colleagues were carrying out their research) as the "subculture of parasuicide" (or, confusingly, "parasuicide subculture" or even "attempted suicide" subculture) hypothesis. Unfortunately, the vexed issues of the definition and perception of parasuicide were glossed over, but undoubtedly the general hypothesis of a "subculture of parasuicide" in areas with high parasuicide rates could be extended to incorporate these aspects also. In other words, the high rates of parasuicide behaviour in some areas are explained by a distinctive set of perceptions, reactions, attitudes, etc. which can be shown (logically and empirically) to be consonant with high parasuicide rates and which are absent or diametrically opposed in low-rate parasuicide areas.

In a further paper, on the relationship of social class to the characteristics of parasuicides, Buglass (1976) showed that of the 37 items (demographic, social and medical) examined, 28 for men and 32 for women showed a significant relationship with social class. "Lower class" parasuicides were more often characterised by a variety of social problems, including overcrowding, trouble with the law, debt, unemployment and violence in interpersonal relationships. They were more often diagnosed as personality disorders whereas higher class parasuicides were more likely to be diagnosed as depressive. Buglass notes that "lower class" patients experience more hardship and also show a different style of interpersonal behaviour. In times of stress they apparently tend to resort to action (physical force, temporary marital separation). Referring to work by Newson (1963), showing that working class mothers are more directive towards their children and give less importance to verbal reasoning, and by Bernstein (1971), demonstrating differences in linguistic style between social classes which permit certain forms of feeling and

behaviour and restrict others, Buglass concludes:

> "Some lower class parasuicide may be explained by the habitual differences in styles of behaviour and the preference for feelings to be expressed in action rather than in words." (Buglass, 1976: 116)

Further work on cultural differences in parasuicide is suggested.

A limited investigation of parasuicide as a "subcultural phenomenon" is found in Kreitman et al. (1970). The authors argue that many parasuicide patients come from a segment of the community in which "self-aggression is generally recognised as a means of conveying a certain kind of information" and where "the [parasuicidal] act is viewed as comprehensible and consistent with the rest of the cultural pattern, and possibly as appropriate behaviour in some circumstances, even if not formally condoned". The individual living in this "attempted suicide subculture" can perform an act (parasuicide) which "carries a preformed meaning: all he requires to do is invoke it". The formal hypothesis which follows is that "there is a subculture in contemporary society in which the communicational functions of attempted suicide are particularly well defined". One salient feature of this subculture will be its relatively high parasuicide rate. More generally, it is expected that parasuicide "must be a behavioural option which is more readily available to members of the postulated subculture than to individuals in the society at large". The hypothesis therefore leads to the prediction that parasuicide rates should be higher among those in the putative subculture than for the population at large. Operationally, the carriers of the subculture were defined as the family and intimate friends of a

series of parasuicide patients. It was hypothesised that parasuicide in this group (the contact population) would be more widespread than would be expected in a matched sample from the general population. The main finding did indeed support the hypothesis: at least seventeen of the contact population were admitted to hospital following an episode of parasuicide, a figure significantly greater than the expected number of 4.23.

This study, although methodologically innovative, is limited by an insistence upon social interaction between individuals as a definitional attribute of subculture, and therefore the identification of the members of the subcultures as friends and relatives of a particular parasuicide. In effect, these decisions led to the rejection of any linking of subculture to a particular geographical area, and to the conceptualisation of each parasuicide-family-friend grouping as a subculture. Both these implications are felt to be unhelpful and misleading by the present author.

The results of an empirical investigation by Robertson and Cochrane (1976) are also worth considering in this context. Noting a dramatic increase in parasuicide among Edinburgh men aged under 25 years over the period 1962-67 (while the rate for men aged 40 and over remained static), they posited that a change in the "world-view" of young people had occurred and that this had been responsible for the differential increase in parasuicide. The elements of this change were seen as: (a) an emphasis on the importance of "self-fulfillment"; (b) a belief that society, rather than the individual, should be responsible for providing the means to personal fulfillment; and (c) a resulting tendency to regard social and material deprivations as obstacles to self-fulfillment. A detailed set of

hypotheses was tested on 100 male parasuicides and 100 controls. Findings supported the view that changes of the type suggested had taken place in the consciousness of young people, but these did not appear to relate to the trend in parasuicide among the young.

3.6 Conclusion

Despite the accumulation of a number of empirical investigations utilising a cultural perspective, there is scanty evidence of an association between subcultural attitudes, norms and values, on the one hand, and the incidence of parasuicide, on the other. It is therefore surprising to discover that the "subculture of parasuicide" hypothesis has almost acquired the status of a proven theory in the literature. Kessel (1965), Evans (1967), Koller and Slaghuis (1978), Morgan (1979) and Henderson and Williams (1974) all suggest that changes in subcultural attitudes may be responsible in part for the present status of suicidal behaviour. It is argued (e.g. Sale et al., 1975) that parasuicide appears to have become, for an increasing proportion of the population, an acceptable means of coping with interpersonal stress; consequently a profitable approach to primary intervention may be to alter subcultural attitudes to suicidal behaviour (Sale et al., 1975; Henderson and Williams, 1974; Mills et al., 1974). It should be noted that in all cases the assumption is that high or increasing parasuicide rates are linked to tolerant or (more) tolerant attitudes, and low or declining rates to (more) unfavourable attitudes. Thus, Koller and Slaghuis (1978) suggest that more intolerant public attitudes may be an important factor in the noted decline and steadying of parasuicide rates in Hobart between 1973 and 1977. Conversely, Morgan (1979) points to the dramatic increase in DSH in the 1970s in Britain and

the trend towards more tolerant attitudes among the public. "We have encouraged individuals in crisis to use self-harm as a signal of distress." Only Bancroft et al. (1979), mindful of the negative findings of Sale et al. (1975), cast doubt on the possibility that certain parasuicides may "come from a subculture where there is less stigma attached to 'manipulative' behaviour". Pending an adequate empirical test of the subculture of parasuicide hypothesis, such scepticism appears to be reasonably well founded.

Chapter 4 HYPOTHESES: DERIVATION, DESCRIPTION AND IMPLICATIONS

4.1 Introduction

In Chapter 3 I drew attention to the possibility that variation in the cultural structure of societies and sub-societies might be crucial in explaining and understanding variation in rates of suicidal behaviour. With reference to parasuicide in particular, I noted the suggestion (arising out of research carried out at the MRC Unit for Epidemiological Studies in Psychiatry in Edinburgh) that subcultural factors might help to account for area-based differences in the incidence of the behaviour. However, it was shown that although the "subculture of parasuicide" hypothesis has almost acquired the status of an accepted, proven theory among certain psychiatrists, it remains without any definitive experimental support. The present study constitutes the first attempt in Great Britain to submit this hypothesis to a critical empirical scrutiny. The design and methods are discussed in Chapter 5 and the research instruments in Chapter 6. In this chapter I state formally the main alternative (and null) hypotheses, commenting upon the assumptions which underlie them and their implications for the conduct of the investigation. Middle-order hypotheses relating to the various elements of culture (see Chapter 2) investigated in this project will also be set forth in this Chapter. Lower-level hypotheses relating to specific items in the various questionnaires and research instruments, will be detailed in Chapter 7.

4.2 Major (alternative) hypothesis

Areas with high parasuicide rates (HRAs) are also characterised by a distinctive subculture. This subculture, maximally expressed among the working class living in a predominantly working-class area, is held to be distinct from the dominant local culture, although not in every respect. Its system of values, norms and beliefs facilitates and permits the form of behaviour labelled parasuicide to a considerable degree. Predominantly middle-class, low-rate parasuicide areas (LRAs) are taken as representative of the dominant Edinburgh culture. In such areas it is expected that there will be an absence of cultural elements conducive to parasuicide. (Null hypothesis: areas with different parasuicide rates will not differ in their cultural meaning systems.)

4.2.1 Middle-order (alternative) hypotheses

(1) Value-orientations or "conceptions of the desirable" will not be similar in the two area-types. In particular, the HRA area will show a tendency towards a higher valuation of action and activity (over contemplation); fatalism and powerlessness (rather than mastery); collateral/fraternal (rather than individualistic) relationships; present (rather than future) time orientation; and a pessimistic (rather than optimistic) attitude towards human nature.

(2) Normative evaluations and expectations of behaviour will differ in the two areas. In the HRA officially "deviant" conduct will be proscribed, and officially "normative" conduct prescribed, to a significantly lesser degree than in the LRA.

In particular, parasuicide and suicide will be more highly tolerated in the HRA. Overall, there will be a greater tendency for more permissive attitudes (evaluations) in the HRA than in the LRA. Likewise, officially deviant behaviour will be more expected, and normative behaviour less expected, in the HRA compared to the LRA. The relevant items of behaviour to be investigated in the study will be those which are predicted to generate the most extremely differentiated evaluations and expectations in the HRA and LRA; and which have a demonstrable empirical or conceptual association with parasuicide and the working class subculture. The items finally selected relate to the following themes: the non-deferred gratification pattern (NDGP); violence towards the self; conflict and violence in family relationships; problem-solving and sharing; traditional sex-role behaviour/patriarchy; integration into society; use of alcohol and drugs; toughness and trouble.

(3) Cognitive, affective and moral evaluations of parasuicide will differ in the two areas. In the HRA there will be a less marked tendency to define "parasuicidal" actions as death-oriented; a greater likelihood of more tolerant, permissive attitudes towards such actions; and a greater reluctance to consider the behaviour morally wrong.

(4) Experience of suicidal behaviour (especially parasuicide) is likely to be more extensive in the HRA than in the LRA. HRA residents will believe that parasuicide is more common in the area, and will report more lifetime contact with all forms of suicidal behaviour (particularly among relatives and close friends) than their LRA counterparts. In general, the greater

the contact with suicide and parasuicide, the more favourable will be the evaluation of the behaviour.

4.3 Secondary (alternative) hypothesis

Differences in values, norms and other elements of the sub-cultural meaning system (what I call "cultural distance") between parasuicides and the general population in the high-rate area will be relatively smaller than the cultural distance between parasuicides and the general population in the low-rate areas. That is to say, LRA parasuicides are expected to be more "deviant" in relation to the general population living in their area than are HRA parasuicides in relation to their local non-parasuicides. (Null hypothesis: the two areas will not differ in respect of "cultural distance" between patients and controls.)

4.4 Derivation of hypotheses

4.4.1 Subculture of parasuicide versus parasuicidal subculture

The major hypothesis concerns the possible existence of a sub-culture of parasuicide not a parasuicidal subculture. I am here making the same distinction which Matza (1964) applied in the area of delinquent behaviour. By a delinquent subculture he was referring to a meaning-system which constrained individuals to act in a manner which was oppositional to conventional culture. The precepts of the subculture were held to be the immediate cause of delinquent acts. A subculture of delinquency, on the other hand, was a setting in which the commission of delinquency was common knowledge among a group of juveniles, but these individuals could also act conventionally. They

were not held to inhabit a separate normative world. In our case, it is expected that an area with a high parasuicide rate is guided by precepts and customs which are delicately balanced between conventional and deviant alternatives. The customs of the subculture may allow parasuicide and even suggest it, but parasuicide is not demanded nor necessarily considered a preferred path. This subculture is not a contraculture. It is likely to share much in common with conventional culture, but also to offer definitions, customs, valuations and norms which legitimate parasuicidal behaviour.

4.4.2 Geographical location of the subculture of parasuicide

The geographical location of the subculture of parasuicide (working-class, high-rate parasuicide areas) follows from the epidemiological findings that all three extremely high-rate parasuicide areas in Edinburgh are overwhelmingly working-class in social composition. In the lowest rate areas, on the other hand, the social composition is mainly middle-class. This relationship between social class composition and parasuicide rates is shown quite clearly in Table 4.1. There are no high-rate parasuicide areas which are predominantly non-manual in social composition, nor are there any low-rate areas in which the manual classes are over-represented. When the twenty-three city wards are rank-ordered according to the percentage of the area population in semi- and unskilled occupations (based on the 1971 Census) and according to their mean parasuicide rate for the years 1968-79, the Spearman rank correlation coefficient (r_s) equals +.74, significant beyond the 1% level. As the proportion of the population in semi- and unskilled occupations increases, so - broadly - does the parasuicide rate of the area.

Table 4.1. Relationship between social class composition and parasuicide rates in Edinburgh city wards

Parasuicide rate of ward**	Social class composition of ward*		
	Nonmanual classes over-represented - Manual classes under-represented	Typical of City	Nonmanual classes under-represented - Manual classes over-represented
High	-	-	St. Giles Pilton Craigmillar
Above Average	St. Andrews	George Square Calton	Holyrood Gorgie-Dalry Central Leith
Average	Colinton	Liberton Broughton	Sighthill South Leith
Low	Newington Morningside Merchiston Corstorphine Murrayfield/Cramond St. Bernard's Portobello	West Leith Craigentinny	-

* Based on 1971 Census

** Based on mean parasuicide admission rate for years 1968-1980

4.4.3 Referent of the subculture of parasuicide

The choice of referent was dictated by the following findings. Firstly, that there is in Edinburgh (Kreitman, 1977: 25) as elsewhere (see, e.g., Whitlock and Schapira, 1967; Bancroft et al., 1975; Morgan et al., 1975) an inverse relationship between parasuicide and social class. For instance, in Edinburgh during the period 1976-79 there was an eightfold difference in male parasuicide admission rates between social classes I and II (117 per 100,000) and class V (922 per 100,000). Secondly, this relationship holds regardless of the overall parasuicide rate of the area; consequently the highest rate is to be found among unskilled manual workers resident in a high rate parasuicide area. It was therefore concluded that the most likely referent for the subculture of parasuicide would be working-class individuals living in a predominantly working-class high-rate parasuicide area. Conversely, the referent for the dominant local culture was taken to be middle-class individuals residing in a predominantly middle-class, low-rate parasuicide area.

The emphasis on an area-class interaction in the formulation of the hypothesis also arises out of empirical work on juvenile delinquency by Reiss and Rhodes (1961) and Clark and Wenninger (1963). Reiss and Rhodes note that residential areas may vary considerably in opportunities for cross-class contacts. A difference in the status structure of residential areas may mean that the effects of the class status position are not uniform from one residential status to another. Pressures for conformity to the dominant middle-class cultural system are likely to be more powerfully exerted upon lower-class individuals residing in a middle-class area than upon their

counterparts living in a lower-class area. They conclude that there is no simple relationship between social status and delinquency, since the relative prevalence of classes in an area and the extent to which the class culture of each is diffused to others crucially affects the issue. Clark and Wenninger's findings echo those of Reiss and Rhodes. Within a given community type the minority social class groups conform closely to the norms of the dominant social class. They stress the need to combine the traditional social class concept with that of status or cultural area.

4.4.4 Empirical support for middle-order hypotheses

The middle-order hypotheses specify the cultural elements which are to be assessed in the course of the investigation, and also predict the direction of differences between areas in relation to these elements. The hypotheses which concern the evaluation of parasuicide, and the extent and type of contact with suicidal behaviour, are derived from the literature discussed in Chapter 3. In the same Chapter, I noted that the suggestion of a "subculture of parasuicide" also rested upon certain assumptions about the normative system of the high-rate area. Buglass et al (1970) postulated that the subculture tended to promote impulsive behaviour (rather than long-term planning) and communication of meaning through action rather than through verbal interchange. In the later paper (Buglass, 1976) on social class, the same emphasis is given to the preference for action over words. No references are given in the 1970 paper, and only two in the 1976 paper, to support these assumptions. However, I have followed the trail first laid down in these papers, in order to scrutinise in considerable detail the normative structure of the HRA and its congruence or compatibility with parasuicidal

behaviour.

The hypotheses relating to value orientations and cultural norms are derived mainly from sociological portraits of "working class", "lower class" or "slum" subculture, or the "subculture of poverty". The assumption underlying this procedure - namely, that these concepts are to a certain extent interchangeable - requires some defence since a number of authors, particularly American, have devoted considerable effort to differentiating between social groupings which lie below the middle level of the class/status hierarchy. Thus, Clinard (1970), Banfield (1968), Kahl (1957), Leacock (1971), Reissman et al (1964) and Kohn (1969), among others, distinguish between the lower-class and the working-class; Warner et al. (1949) separate the "upper-lowers" from the "lower-lowers"; and Minuchin et al (1967), Peattie (1971) and Miller (1964) develop different methods for subdividing the lower-class itself. Askham (1969) allocates the Registrar General's social class V "stable" and "unstable" groups. However, even a superficial reading of this literature reveals a lack of consensus among experts about the characteristics of these classes and the essential features which distinguish one from another. Moreover, Reissman et al. (1964) and Blum and Rossi (1961) claim that the "working class" and the "lower class" share certain attributes (as well as possessing others which are unique to each class), while Davis (1946) uses the terms "lower class", "working class" and "under-privileged" as if they were synonymous. In view of this conceptual confusion, I have chosen to disregard the working-lower class distinction when seeking source material which is to serve as the basis for predictions about the normative system of the "subculture of parasuicide".

Tables 4.2 and 4.3 present a selective list of literature sources used to derive middle-order hypotheses relating to value orientations and conduct norms, respectively. However, it should be pointed out that some of the predicted normative attributes of the working/lower-class subculture by no means command universal empirical or theoretical support. I shall discuss some of the contrary views when I evaluate the results of my own investigation in Chapter 9.

4.5 Implications

Whatever the degree of empirical support adduced in this thesis for a subcultural explanation of parasuicide, it would be most unfortunate if the study findings were used to play down the importance of social and economic factors in the aetiology of the behaviour. In Chapter 3 I drew attention to the strong association between poverty, unemployment and parasuicide. It is tempting to speculate that the multiple standardisation exercise carried out by Buglass and colleagues may very well have produced different findings if area populations had also been standardised on a measure of personal income and/or wealth. In addition, we already have evidence that material and situational aspects of class are crucial in understanding high rates of parasuicide among manual workers (see, e.g., Cochrane and Robertson, 1975). In some measure the present investigation was undertaken with a view to testing the heuristic value of a cultural perspective in increasing our understanding of parasuicidal behaviour. Such a perspective was intended to complement, rather than supplant, other more traditional approaches. An integrated theory of parasuicide would undoubtedly be multifactorial and

Table 4.2 Literature sources for derivation of middle-order hypotheses relating to value orientations

Hypothesis	Literature source*
Compared to the dominant local culture, the subculture of parasuicide will place a higher value on the desirability of:	
- action and activity (over contemplation)	Miller & Swanson (1960) Riessman et al. (1964) Bernstein (1958)
- fatalism and powerlessness (rather than mastery)	Matza (1966) Lewis (1968) Clinard (1970) Kahl (1957) Haggstrom (1964)
- collateral/fraternal (rather than individualistic) relationships	Miller & Riessman (1961) Riessman et al. (1964) Willmott & Young (1960) Young & Willmott (1957,1973)
- present (rather than future) time orientation	Leshan (1952) Clinard (1970) Banfeld (1968) Lewis (1968) Haggstrom (1964) Bernstein (1971)
- pessimistic (rather than optimistic) attitude towards human nature	Schneiderman (1963, 1964) Haggstrom (1964) Cohen & Hodges (1963)

* This list is selective rather than exhaustive

Table 4.3 Literature sources for derivation of middle-order hypotheses relating to conduct norms

Hypothesis	Literature source
The subculture of parasuicide will express different evaluations and expectations in respect of:	
- non-deferred gratification pattern (less highly evaluated, less expected, than in dominant local cultures)	Schneider & Lysgaard (1953) Beilin (1956) Straus (1962) Askham (1975) Lewis (1968) Morris (1957) Spinley (1953) Kerr (1958) Bernstein (1958) Tonge et al. (1975)
- conflict and violence in family relationships (more tolerated, more expected, than in dominant local culture)	Matza (1966) Blum & Rossi (1968) Tonge et al. (1975)
- problem-solving and -sharing (less highly evaluated, less expected, than in dominant local culture)	Minuchin et al. (1967) Tonge et al. (1975) Komarovsky (1962) Rainwater et al. (1959)
- traditional sex-role behaviour/ patriarchy (more highly evaluated, more expected, than in dominant local culture)	Lewis (1968) Riessman et al. (1964) Cohen & Hodges (1963) Miller & Riessman (1961)
- integration into society (less highly evaluated, less expected, than in dominant local culture	Lewis (1968) Matza (1966) Knupfer (1947) Cohen & Hodges (1963) Miller & Riessman (1961)
- toughness and trouble (more tolerated, more expected, than in dominant local culture)	Clinard (1970) Miller (1958) Riessman et al. (1964) Cohen & Hodges (1963)
- use of alcohol and drugs (more tolerated, more expected, than in dominant culture	Minuchin et al. (1967) Dight (1976) Ritson et al. (1981) Kreitman & Chowdhury (1973)
- deviant behaviour in general (more tolerated, more expected, than in dominant local culture)	Clinard (1970) Mays (1954) Carter & Jephcott (1954) Morris (1964) Mannheim (1940)

complex, including psychological, social, economic and psychiatric elements in the model. However, I consider that would be presumptious and premature to formulate such a theory at the present time.

Chapter 5 DESIGN AND METHODS

5.1 Study Design

5.1.1 Rationale of the design

In the last Chapter the formal hypotheses of the study were presented. In order to test these hypotheses it was necessary to formulate a research design which would allow a comparison of samples from the general population in the two area-types (the high rate area, where the putative subculture was located; and the low rate area, where the subculture was expected to be absent), as well as comparisons of the general population and parasuicides within each area. The investigation of control (general population) samples to test the major hypothesis, omitting altogether any consideration of actual parasuicides, follows logically from the conceptualisation of the subculture of parasuicide. Unlike other attempts to undertake empirical tests of the subcultural hypothesis (e.g. Ball-Rokeach (1973) on the subculture of violence), the present approach is not based on a distinction between those who possess a certain trait or behave in a certain manner ("violent" or "parasuicidal"), on the one hand, and those who do not (non-violent or non-parasuicidal), on the other. We do not hold that there is a subculture appertaining to parasuicide and another (or others) appertaining to non-parasuicidal members of the general population. The subculture of parasuicide hypothesis relates to area populations: areas with high rates of parasuicide are characterised by a generalised subculture which, it is suggested, is congruent with or conducive to parasuicide, and can be contrasted with the dominant culture found in low-rate parasuicide

areas. To test the major hypothesis some form of random sampling of populations in the two area-types is therefore required. However, if we find differences between such general population control groups, all we have discovered is the existence of area-based, class-related subcultures. The link with parasuicide has yet to be established. If Area A parasuicides differ from Area B parasuicides in the same way as Area A controls differ from Area B controls, then we can conclude that Area A and Area B parasuicides are typical/representative of their respective areas. But we cannot draw any conclusions about the relevance of the difference in area subcultures to the difference in the incidence of parasuicide in the two areas. The way of relating the two aspects which enables us to draw some conclusions about the role of subculture in facilitating the behaviour is as follows:

Firstly (MAJOR HYPOTHESIS), by comparing control groups on the various dependent variables - in order to establish whether HRAs and LRAs differ in the expected direction. If they do not differ, then of course they are not characterised by different subcultures and further analysis is unwarranted.

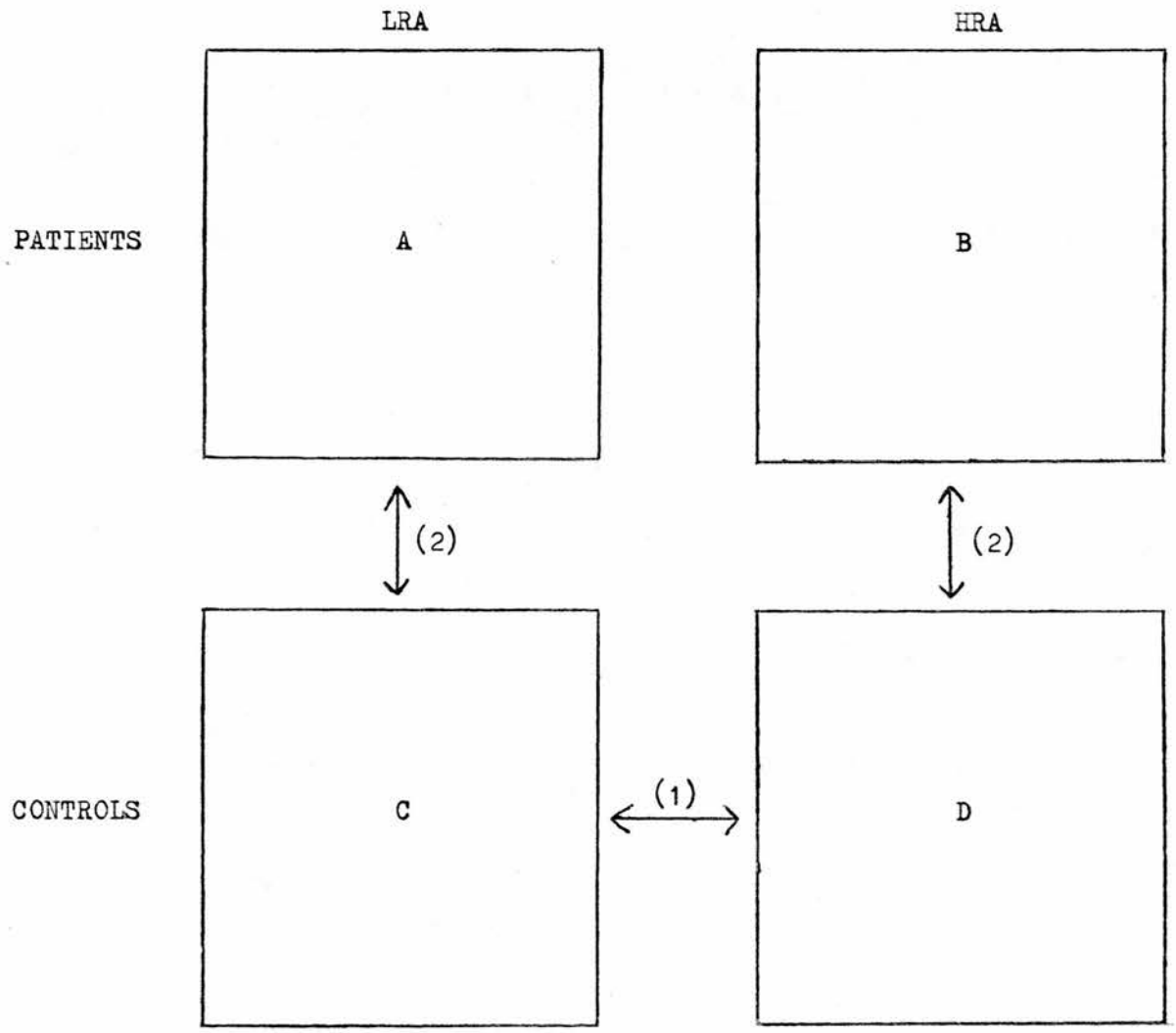
Secondly (SECONDARY HYPOTHESIS), if differences between control groups have been established, then differences between parasuicides and controls within each area-type are examined. Cultural variables may have explanatory power in both areas, neither area or in one area only.

The secondary hypothesis concerns putative cultural differences between patients and controls within each area-type. Are the cultural values, norms, etc. of parasuicides similar to their non-parasuicidal neighbours? Do they form part of the subculture of the area or are they apart from or marginal to it, perhaps even forming a

subculture of their own? In order to answer these questions, certain fundamental decisions have to be made about the selection of both parasuicides and controls. It is known from previous unpublished research that in many respects parasuicides are not typical of their area populations. A comparison of hospitalised parasuicides from a particular area of Edinburgh with the general population of that area in respect of key socio-demographic variables will show that the former group tends to have significantly more females, to be significantly more likely to be unemployed, etc. Additionally, parasuicides are not randomly distributed throughout a particular geographical area, but tend to cluster in certain sub-areas. If we are to examine the typicality of parasuicides compared to their neighbours, it is therefore not sensible to compare groups of parasuicides with an entirely random selection of area populations. Too many possible sources of similarity or variation between patients and controls would remain uncontrolled - e.g. age, sex, social class.

The final choice of study design reflects the need to reconcile the differing emphases of the major and secondary hypotheses, i.e. control samples which are random, but not entirely so. Relevant data were gathered on four separate samples (see Chapter 6): two groups of parasuicide patients, one from a high rate parasuicide area (HRA) with a predominantly working class population, the other from a low rate parasuicide area (LRA) with a predominantly middle-class population; and two groups of matched controls, one from each area-type. Within each area-type each parasuicide was matched with a control chosen at random from the general population within certain constraints. This procedure satisfied the twin requirement of quasi-random samples in the two area-types and the possibility of comparing parasuicides and general population within each area-type.

The design can be represented diagramatically as follow:



Groups C and D are connected with an arrow marked (1) to show that the major hypothesis is to be tested by comparing control groups: the putative subculture is expected to be located among HRA controls (group D) and to be absent among LRA controls (group C). Once this has been established then evidence relating to the secondary hypo-

thesis is explored by comparing cultural differences between patients and controls in the LRA (groups A and C) with cultural differences between patients and controls in the HRA (groups B and D).

5.1.2 Matching criteria

The selection and representativeness of the parasuicide sample, the choice of sampling frame for selecting controls, and the extent to which matching criteria were successfully applied - these issues are covered in the next section of this Chapter. Here I want to consider the matching criteria themselves. These were adopted with considerable care, since it is recognised that any variable used to make groups or individuals comparable can not at the same time differentiate between these groups or individuals. Finally, it was decided to match each patient pairwise with a control by sex, age (within two years) and area of residence (within 400 yards, if possible). The variables of age and sex were chosen because both are strongly associated with parasuicide. A representative hospitalised parasuicide sample is known to differ from a random general population sample because it is younger than expected and has a significantly greater preponderance of women. Area of residence was considered to be the most important matching criterion. Unpublished evidence from Edinburgh (and published data from Mannheim, West Germany - see Welz, 1980) suggests that parasuicides tend to be concentrated in certain streets and neighbourhoods. Thus, even within a high-rate parasuicide area there may be a degree of cultural differentiation between different sub-areas and sub-groups. The socioeconomic composition of a high rate parasuicide area, while predominantly working class, may also not be entirely homogeneous, containing pockets of lower-middle class and middle class owner-

occupiers. Consequently, there is a need to ensure that any cultural differences between parasuicides and controls (the general population) are not artefactual, i.e. arising because the two groups belong to different subcultures and proclaim a different social class affiliation. Matching by area of residence (within a limit of only 400 yards apart) enhances the possibility that parasuicides and controls do indeed belong to the same overarching subculture. This matching criterion should also ensure comparability between groups on social class composition, inasmuch as very small natural geographical areas tend to be inhabited by persons of similar socio-economic status. Clearly, if the matching procedure is successful, the area groups will not differ on age and sex profile. Some difference is possible, on the other hand, in relation to social class composition. This, however, would constitute a substantive empirical finding (as, of course, would any other difference between parasuicides and controls).

5.1.3 Choice of high- and low-rate areas

In order to select the geographical area where the putative sub-culture of parasuicide was most likely to be located, I firstly computed an average parasuicide (admission) rate for each of the city wards over the period 1968-1980. The results of this analysis are reported in Table 5.1. (It was considered permissible to use an average rate, since the ranking of city wards by parasuicide rate was remarkably stable over the period: $r_s = 0.78$, $p < .001$). Three city wards were characterised by extremely high parasuicide rates: St. Giles, Pilton and Craigmillar. Examination of the social composition of each of these three areas revealed that while the proportion of the male population working in semi- and unskilled occupations was

Table 5.1. Division of Edinburgh according to the rank order of parasuicide (admission) rates in the city wards, 1968-1980 (In quartiles)

Ward	Mean 13 year admission rate (M+F)	Number of parasuicide admissions in 13 years (M+F)		
Area I (High rate areas) (>550 per 100,000)				
St. Giles	793.4	850		
Craigmillar	632.1	1523		
Pilton	566.1	1526		
			3899	26.9%
Area II (Above average areas) (350-450 per 100,000)				
Calton	436.2	565		
St. Andrew's	389.4	350		
George Square	380.9	542		
Holyrood	379.3	289		
Central Leith	372.4	490		
Gorgie-Dalry	351.7	578		
			2814	19.4%
Area III (Below average areas) (275-330 per 100,000)				
Sighthill	328.6	879		
Colinton	305.1	1083		
Liberton	301.4	1121		
Broughton	296.6	476		
South Leith	295.9	450		
			4009	27.6%
Area IV (Low rate areas) (<275 per 100,000)				
Portobello	272.1	464		
West Leith	237.3	341		
Merchiston	222.5	371		
Craigentinny	211.0	421		
St. Bernard's	205.7	507		
Newington	204.9	503		
Morningside	196.6	352		
Murrayfield-Cramond	168.3	515		
Corstorphine	124.9	303		
			3777	26.1%

Median rate = 300.7 per 100,000
Average rate = 334.8 per 100,000

virtually identical (38.1% in St. Giles, 37.1% in Craigmillar and 36.8% in Pilton), there was a considerably greater preponderance of men in professional, managerial and intermediate occupations in St. Giles (31.5%) than in Craigmillar (20.3%) or Pilton (18.6%). (All data are taken from the 1971 Census.) It was felt that the choice of high-rate area lay between Craigmillar and Pilton, since the major hypothesis located the subculture of parasuicide in an area characterised not only by a high parasuicide rate, but also by an overwhelmingly working class social composition. The final decision to study Pilton was taken largely on the (somewhat negative) grounds that Craigmillar had been considerably over-researched and had also received a considerable degree of attention and support, largely due to the effects of the Craigmillar Festival Society. Pilton was an area with a similar degree of deprivation, without enjoying the twin benefits of academic scrutiny and an internally generated drive to exert social and economic change. It was felt that the predicted yield of approximately 120 hospitalised parasuicide patients from Pilton in a full year would be more than adequate for the purposes of the study.

The choice of suitable low-rate areas to represent the dominant Edinburgh culture was somewhat more difficult. In the first place, it was clearly going to be necessary to select the parasuicide (and, therefore, control) samples from at least two city wards, since too few parasuicide cases would be generated over a fixed period (e.g. one year) in one ward alone. Table 5.1 shows the lowest rate areas, with five wards having rates of around 200 or less. Corstorphine and Murrayfield/Cramond had the lowest rates and almost an identical social class composition, with over 66% of males in professional, managerial and intermediate occupations, and less than 12% in semi-

and unskilled occupations (1971 Census). However, it was still considered necessary to sample from one more LRA, because of the paucity of parasuicide cases in Corstorphine (estimated yield of 27 hospitalised parasuicide cases in a full year) and Murrayfield/ Cramond (estimated yield of 42 such cases). Morningside was ruled out, because the parasuicide incidence was so low (about 25 cases per year) and also because it contained Edinburgh's psychiatric hospital within its boundaries. The choice for the third LRA therefore lay between Newington and St. Bernard wards. Newington was finally chosen because, firstly, when the study was planned it had the slightly lower parasuicide rate; secondly, its social class distribution was slightly more skewed towards the middle classes (58.9% in professional, etc. occupations versus 55.3% in St. Bernard); and, thirdly, it was discovered that it would not be possible to sample from the general population in St. Bernard's using the preferred method (general practitioner age-sex register - see Section 5.2 below), since no such register was then in operation in any practice serving the inhabitants of the area.

5.1.4 High- and low-rate areas compared

Table 5.2 compares LRAs, HRA and Edinburgh city as a whole on selected Census variables, while Table 5.3 presents a similar comparison on social and medical variables. Two of the LRAs, Corstorphine and Murrayfield/Cramond, present similar profiles on Census variables. Newington differs somewhat from these other LRAs, particularly with regard to socioeconomic status (fewer owner-occupiers, fewer households with cars, fewer in the highest SEGs), age composition (somewhat older population, especially female), marital status (fewer married), economic activity (fewer economi-

Table 5.2. Comparison of LRAs, HRA and Edinburgh city on selected census variables*

	Low Rate Areas (LRAs)			High Rate Area (HRA)	Edinburg City
	Newington	Corstorphine	Murrayfield-Cramond	Pilton	
Persons	18667	22762	29660	30546	429776
Households (present)	7567	8132	9894	9352	157898
N. per 1,000 private households present					
Owner-occupied	582	754	644	48	469
Council	157	100	262	829	316
Unfurnished	139	127	72	120	155
Furnished	122	19	22	3	60
Over 1½ persons per room	24	16	28	107	54
No car	586	370	349	783	618
Gender					
% males	43.8	46.9	46.8	48.3	46.4
% females	56.2	53.1	53.2	51.7	53.6
Age					
% aged 0-14 years	15.8	23.3	25.0	33.0	22.9
% aged 15-34 years	28.1	22.8	23.1	26.6	26.7
% aged 35-64 years	37.3	40.1	40.3	31.3	36.3
% aged 65+ years	18.7	13.8	11.6	9.1	14.1
Marital status (population 15+ years)					
% single, widowed, divorced	46.8	29.9	33.5	33.3	38.3
% married	53.2	70.1	66.5	66.7	61.7
Birthplace					
% in Scotland	79.1	86.3	82.6	93.8	87.3
% elsewhere	20.9	13.7	17.4	6.2	12.7
Number economically active per 1,000 population, 15+ years					
Males and females	479	568	584	667	604
Males only	610	781	804	865	784
Females only	380	389	407	493	454

Table 5.2. continued ...

	Low Rate Area (LRAs)			High Rate Area (HRA)	Edinburg
	Newington	Corstorphine	Murrayfield-Cramond	Pilton	City
Socio-economic classification, economically active and retired males					
% professional, managerial and intermediate (SEG 1, 2, 3, 4, 5, 6, 13)	56.4	64.6	65.2	18.2	41.4
% skilled manual (SEG 8, 9, 12, 14)	26.6	23.7	21.6	43.6	33.0
% semi- and unskilled manual (SEG 7, 10, 11, 15)	12.7	9.4	11.1	36.0	21.3
% unclassified and armed forces (SEG 16, 17)	4.2	2.3	2.1	2.2	4.3
Number per 1,000 persons present in private households					
Age 0-4	50	75	64	104	73
Age 5-14	108	158	186	225	155
Students 15 years +	102	46	62	17	48
Males 65 years +	58	50	40	36	49
Females 60 years +	175	124	104	84	128
Child ever born per 1,000 married females in private households					
16-29 years	78	105	111	177	117
30-44 years	212	191	227	299	235
45-59 years	190	176	198	286	214
Migration - rates per 1,000 population 15 years +					
One year migrants within local area	82.7	61.3	58.0	81.1	80.6
One year migrants into local area	52.2	43.0	50.4	11.7	40.0
Five year migrants within local area	206.8	202.3	213.7	309.6	240.4
Five year migrants into local area	155.9	115.2	132.2	29.8	109.3

* Source: 1971 Census

cally active males) and more students. However, on virtually all items the contrast between area-types is far greater than any differentiation within the LRA. In particular, the socio-economic status of HRA is strikingly lower than that of the LRAs, while its economic activity rate is higher; its age structure is considerably more skewed towards youth; HRA residents are more likely to be born in Scotland; and its migration pattern is characterised by more movement within, and less movement into, the area, compared to the LRAs. The gender composition of all areas is similar, while the ward most deviant in respect of marital status structure is Newington.

Turning to Table 5.3, we find the differences between HRA and LRAs are shown in even sharper contrast. Overall, Pilton (HRA) ranks third out of the 23 Edinburgh city wards in the frequency and extent of high ratings on the various medical and social indices, while the LRAs rank twentieth and twenty-second. In particular, we should note that the HRA is rated with the most problems in respect of poverty and adolescents, and second worst in respect of children. It is ranked below average on all clusters except accidents, while all three LRAs are ranked above average on all clusters.

5.1.5 Profile of the HRA

Pilton lies on the north/north-west periphery of Edinburgh, extending from Granton Road in the east to, but excluding, Silverknowes in the west, bounded by Ferry Road in the south and by the Granton-Cramond foreshore in the north. We have already noted that the population is relatively younger than that of the LRAs and of Edinburgh as a whole. However, the average age breakdown for the

Table 5.3. Comparison of LRAs and HRA on selected social and medical variables*

	Low Rate Areas (LRAs)			High Rate Area (HRA
	Newington Rank**	Corstorphine Rank**	Murrayfield-Cramond Rank**	Pilton Rank**
Education Department				
Child Guidance referrals	5	10	16	18
Children receiving clothing grants	19	22	18	2
Children receiving free school meals	21	22	19	2
Truants	7	19	11	2
Youths unemployed	21	20	15	2
Public Health Department				
Livebirths	20	7	12	2
Illegitimate births	2	13	6	16
Social Work Department				
Blind Register	20	14	16	17
Deaf Register	15	5	6	9
Mentally Handicapped Register	19	20	23	7
Physically Handicapped Register	9	21	16	4
Children taken into care	18	10	18	7
Meals on wheels	5	15	10	11
Home helps	16	18	7	5
Reporter of Children's Hearings				
Children referred to the Reporter	18	23	21	1
V.D. Referrals				
Males	3	19	21	16
Females	16	7	9	1
R.S.S.P.C.C.				
Referrals	12	15	20	1
Eviction Orders	21	22	6	2
Electricity Disconnections	18	23	20	1

Table 5.3. continued ...

	Low Rate Areas (LRAs)			High Rate Area (HRA
	Newington Rank**	Corstorphine Rank**	Murrayfield-Cramond Rank**	Pilton Rank**
Scottish Home and Health Department Data				
Schizophrenia	4	23	15	11
Alcoholic Psychosis, Alcoholism	15	18	17	7
Depressions	18	9	3	1
Total admissions to mental hospitals/ psychiatric units	11	23	12	6
Infections and parasitic diseases	7	9	21	13
Malignant neoplasms	11	16	18	23
Heart and Circulatory diseases	11	15	18	20
Computed problem cluster scores				
Children	19	23	21	2
Accidents	17	21	22	13
Handicap	12	22	23	11
Poverty	21	23	19	1
Adolescents	18	23	19	1
Physical Health	14	16	22	11
Old/Chronic	16	22	23	11
Mental Hospital	13	23	17	7
Total problem score	20	22	22	3

* Source: Buglass et al. (1980)

** The rank given is the placing of the ward among all 23 wards on the particular variable. The highest rate is always given a rank of 1 and the lowest 23. All data refer to 1975, except: youth unemployment (1976); blind, deaf, mentally and physically handicapped registers (1976); meals on wheels, home helps (1977); schizophrenia, alcoholic psychosis and alcoholism, depressions, total admissions (1974); problem cluster scores (1974). For details of actual rates, population bases for the computation of rates, and calculation of problem scores, see Buglass et al., 1980, Par 1.

area disguises wide differences among the separate districts within the area. In general, the population varies from very young in the newest estates gradually through to relatively old in the more established districts. The only district which does not quite fit the pattern is West Pilton, where a high proportion of young people have been maintained despite the older age of the buildings. A result of this imbalance is that about 40% or more of the population of West Pilton, West Granton and Pennywell are under 20 years of age.

> "With this proportion of young people it is likely that there would be too few adults in the community to set the area's social standards and to ensure that most youngsters conform to them. In other words, the very foundation of community life and social cohesion was lacking, because there were too many youngsters to handle. This would be especially important in West Pilton where, despite the high proportion of children, there was a relatively low level of active adults (aged between 20 and 60." (City of Edinburgh District Council (CEDC), 1978: section A2.2)

The Pilton area is not homogeneous in the type and quality of the built environment. At the east end of the ward (Boswall) nineteenth century houses and a garden-city type council estate can be found. Moving west we pass through the grey, semi-detached sprawl of Pilton and the barrack blocks of Wardieburn. Further west again, West Pilton and the southern part of Muirhouse are representative of the standard council estate designs of the 1940s and 1950s, while West Ganton and Northern Muirhouse represents the 1960s version with point blocks, raised walkways and free-flowing public spaces.

> "The lasting impression one takes away is of dull, drab

buildings, large areas of which appear all too similar, interspersed with particles of vacant land. This almost total lack of environmental quality is disturbing and requires redressive action." (CEDC, 1978: section 3.1)

While the physical condition of the local authority housing stock varies from area to area, West Pilton stands out as the area with most physical problems in terms of appearance, vandalism, dampness, heating problems, etc. "All of this confirms the poor image and self-image to the visitor and inhabitant alike" (CEDC, 1978: section A3.1). The consequence of this state of affairs is spelt out graphically in the Pilton Study, a report prepared by the Social and Community Development Programme Central Research Unit of Edinburgh District Council's Planning Department:

"From discussions in the Area Service Team it has been established that a number of long-established and stable members of the community who are capable of positive social contribution to the area are moving out. They feel that they cannot accept the deteriorating environment and the stigma which the rest of the community attaches to their present address. [There is evidence that a Pilton address decreases one's chance of getting a job or obtaining credit at some shops.] Many tenants now consider West Pilton as an emergency stop-gap until they can find accommodation in a more acceptable environment. Also, the concentration of 'problem families' in the area leads to a high incidence of vandalism and complaints of anti-social behaviour." (CEDC, 1978: sections A3.1, A3.2)

Not surprisingly, houses in West Pilton are extremely difficult

to let. On the other hand, it is one of the few areas of the city (besides Muirhouse and Niddrie) where a house can be obtained quickly with a low number of points. Consequently, only those who are desperate and effectively have no choice in the matter (e.g. because of pressing personal or social problems), or those who might find Pilton's present condition acceptable, tend to accept houses in the area. As a result, even though there may be no official policy of "dumping problem families" in Pilton, other policies and economic forces will have the same effect.

> "Because Pilton is seen as the least desirable area of choice, there will be self-selection by the tenants themselves." (CEDC, 1978: section A3.2)

> "The concentration of 'problem households' [in the area] places a burden on an overworked Social Work Department, who thus find difficulty in giving adequate support. The concentration thus leads to more vandalism and anti-social behaviour, which in turn induces an outward movement of the more stable members of the community." (CEDC, 1978: section 3.3)

The Pilton Study details other problems characteristic of the area, including poorly used and generally unattractive public spaces, inadequate drainage, obstruction caused by car and lorry parking, the volume of refuse ("probably the most serious and constant problem"), lack of choice in shopping in the western half of the area, and limited commercial entertainment facilities. Attention is also drawn to the extent and severity of medical and social problems (see discussion above) and to the level of unemployment in the area. The Report estimates that in April 1978 the local unemployment rate was

9.2% ("the actual level could be much higher"), compared to 6.2% for Edinburgh as a whole.

While there seems to be little disagreement among academics, planners or Pilton residents about the major material deprivations and disadvantages associated with residence in the area, consensus is more variable concerning the crucial issue of community spirit and community identity. In an interesting series of articles in the local newspaper, Louise Tait (1981a, b, c) writes about

> "Friends, roots, commitment and caring - not words you would associate readily with Edinburgh's West Pilton. Not, that is, if you have been influenced by more than 20 years of bad publicity, council reports of 'an absence of community spirit', and a lack of contact with the people of the area" (Tait, 1981a).

Tait claims that local residents take objection to the great emphasis given to the problems of poor housing, vandalism, street refuse, etc., and the failure to recognise the existence of "a lively, warm community, which does a lot to preserve the spirit of West Pilton and takes leading steps in community ventures for the rest of Lothian region ..." (ibid). One of the first playschemes in Lothian region was started in the area, and now West Pilton has an annual gala, numerous youth clubs and church groups, as well as several more loosely organised projects, such as the street warden scheme. Tait draws attention to the high level of commitment to the area among many tenants, as evidenced by the "army" of action groups, e.g. the Pilton Action Committee and the Tenants in Pilton group. While a number of Tait's informants stress the friendliness, openness and

neighbourliness of the area's residents, she also notes the residents' awareness and resentment of the pity, prejudice and antagonism directed towards them.

> "These tenants are fed up being dumped together and classed as rubbish, with no-one looking deeper to find the wealth of good that lives within Edinburgh's so-called 'worst' estate." (Tait, 1981a)

5.2 Methods

5.2.1 Selection of parasuicide subjects

Subjects were obtained by screening all admissions to the Regional Poisoning Treatment Centre (RPTC) at the Royal Infirmary, Edinburgh. The RPTC is a self-contained unit consisting of two wards with room for up to 22 patients, and a two-bedded intensive care unit (see Kreitman, 1977, and Matthew et al., 1969, for a full description of the organisation of the unit). Approximately 98% of all adult (15 years and over) patients admitted to hospital from an Edinburgh address for treatment of self-poisoning are received by the RPTC (Holding et al., 1977). All referrals are admitted regardless of the severity of their physical condition (Matthew et al., 1969). The RPTC also receives cases of self-injury, although these are less systematically referred than the cases of self-poisoning and are therefore likely to be a less representative sample of the total number of such cases.

Unfortunately, we cannot make any definitive statement about the relationship of the hospitalised parasuicide sample to the total

number of parasuicidal episodes occurring in Edinburgh during a particular period of time, either in terms of numbers or personal characteristics. Kennedy (Kennedy, 1971; see also, Kennedy and Kreitman, 1973) has shown that 30% of parasuicidal episodes known to general practitioners, but only 21% of all persons involved in these acts, were not referred to the RPTC. His analysis demonstrates, however, that persons sampled in hospital during 1970 were representative of all medically treated parasuicides on key demographic, social and psychiatric variables, e.g. age, sex, social class, civil state, area of residence, previous parasuicide, etc. The only factor which affected referral to the RPTC was a family history of treated psychiatric disorder.

The analysis by method of parasuicide shows that while 9.5% of all medically treated episodes of parasuicide were self-injury, none was admitted to the RPTC. Over the years 1976-79 6-8% of male parasuicide admissions and 5-6% of female parasuicide admissions to the RPTC were cases of self-injury (Kreitman et al., 1980). Clearly, while the self-injury patients admitted to the RPTC may be representative of all such hospitalised patients, they are not necessarily representative of all medically treated self-injury cases. Again, the extent to which the self-injury sample in the RPTC is representative of all such cases (medically treated and not) is problematic.

There has been no research carried out in Edinburgh on the incidence of parasuicide in the general population or on episodes of parasuicide which receive no medical attention. Kreitman (1977: 7) believes that the number of such cases may be "substantial"; for Parkin and Stengel (1965) the number is "probably small but not

negligible". It is fairly safe to assume that there is little or no concealment of medically serious parasuicide in the community (e.g. where the person is deeply unconscious or the loss of blood in self-injury is substantial). Thus we have to consider only the hypothesis that the extent of non-treated less medically serious parasuicide is such that the hospital sample is not representative of the total number of non-serious parasuicide cases. We can only speculate on this; an empirical refutation is not possible. On the one hand, a case could be made for expecting the suppression of medically non-serious parasuicide in the upper social classes because of the stigma attached to admission to the RPTC (Kennedy, 1971: 32). We could therefore conclude that parasuicide rates for classes I and II (and for areas where these classes are over-represented) would be under-estimates of "true" incidence. On the other hand, it is just as likely that non-serious overdoses in high-rate areas are not brought to the attention of medical practitioners because of their more routine and commonplace nature. Thus, rates in classes IV and V (and in areas where these classes are prominent) would be underestimates.

These must remain speculations. However, as we have already noted (see Chapter 4), during the period 1976 to 1979 the ratio of the class V male parasuicide admission rate to the rate for classes I and II averaged approximately 8:1. Similarly, there was a more than six-fold difference between the city wards with the highest and lowest mean twelve-year parasuicide admission rates. Furthermore, the patterning and magnitude of differences in parasuicide rates between both social classes and city wards has been stable and consistent over at least twelve years. Even Douglas (1967), in the midst of his ferocious onslaught upon the unreliability and invalidity of official suicide statistics, concedes that an

investigator, finding a ten-fold difference in rates between two nations, "might feel that it is plausible to conclude that the one has a higher real rate than the other ..." (p 176).

My own firm impression is that the differences between social classes and between city wards are "real" and cannot be explained away by postulating differential rates of retention (i.e. witholding from medical treatment) of parasuicide cases in the community. There is one final piece of indirect evidence on this point. I have looked at the proportion of patients (aged 15+ years) admitted for the first time to the RPTC after a parasuicidal episode during 1976-78, who reported a previous episode of parasuicide for which they were not treated in hospital. In both area types included in the present study (low rate areas, mainly middle class, and a high rate area, predominantly working class), 15% had such previous admissions. The proportions from each social class with at least one previous non-hospitalised episode of parasuicide were 14.4% in classes I and II, 13.3% in class III, 10.3% in class IV and 14.2% in class V. There is no evidence of any significant trend or inter-class differences here.

Thus, I feel there are no strong reasons for considering that a cohort of patients admitted to the RPTC over a specific time period is biassed in respect of characteristics which are of crucial importance in this study, namely, area of residence and social class. What indirect evidence is available supports this conclusion. Perhaps it is also worth stating that clinical studies of the suicidal phenomenon have traditionally used "samples of convenience" (mostly "suicide attempters" admitted to psychiatric hospital) without even considering the issue of their representativeness. Kreitman (1977: 6) thinks that the majority of studies on

parasuicide are probably still based on such samples. Using the RPTC as a sampling frame does admittedly pose some problems, but still constitutes a considerable advance in a field not noted for its methodological fastidiousness.

Starting in April 1979 I screened all admissions to the RPTC. Patients were eligible for inclusion in the study if they satisfied the following criteria:

(a) admitted after an episode of parasuicide

Following Kreitman (1977: 3), parasuicide was defined as "a non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognised therapeutic doseage". This definition usually excludes intoxication with alcohol alone (Kreitman, 1977: 7-8) but I did include one person who claimed to have been attempting to drink himself to death. Apart from this one case, the extent of the patient's suicidal intention, if any, was not taken into account when a decision was made about eligibility for the study. There was usually no disagreement between patients and medical staff about whether the self-harmful act had been deliberate or accidental (the latter not, of course, being classified as parasuicide). If a patient claimed the overdose was accidental I omitted the case from consideration. (There were no cases of self-harm where patients and staff disagreed about its deliberate or accidental status.) During the course of the study five patients claimed loss of memory of the events preceding their admission to hospital. In all five cases there was evidence from family members and/or friends that the patient had taken an overdose of tablets. In all cases, the significant others believed that the overdose had been deliberate, although three patients had been drinking fairly heavily. These five

patients were included in the study.

(b) admitted from an address in four specific areas of Edinburgh (Newington, Corstorphine, Murrayfield/Cramond and Pilton). The reasons for the selection of these areas were given in section 5.1.3 above.

(c) aged 16 - 65 years only

Children aged 15 and younger were excluded because of the difficulties they would experience in completing interview schedules and questionnaires designed for an adult population. Adults aged over 65 years were also excluded when it was discovered during the pilot phase that the interview was too demanding for this age group. In addition, securing matched controls (as demanded by the research design) for the under-16 and over-65 groups would have been exceedingly difficult. In fact, less than 10% of parasuicide patients would be likely to fall into these age groups.

(d) first-time admissions to the RPTC

Patients with previous admissions to the RPTC were excluded on the grounds that even a short stay on the ward might subsequently influence attitudes, beliefs, behaviour and self-concept in a fairly systematic manner. Since at present we can only speculate on the content of the RPTC subculture, it seemed safer to choose a sample without prior exposure to this environment. I considered the possibility of excluding all but first-time-EVER parasuicides, but this would have prolonged data-gathering to an unacceptable extent, without conferring any additional benefits.

From the date of the inception of the study (April 1979) I checked all admissions to the ward daily, except when I was away from Edinburgh or ill. Twenty-three patients were omitted from the study for these reasons (see Table 5.4). All patients giving an address

Table 5.4. Contact and Response rate for patient sample, by area

Reasons for non-contact and non-interview	LRA N	LRA Contact/ Response Rate	HRA N	HRA Contact/ Response Rate	TOTAL N	TOTAL Contact/ Response Rate
INITIAL SAMPLE	71		77		148	
		CONTACT RATE		CONTACT RATE		CONTACT RATE
CONTACTED	62	87.3%	59	76.6%	121	81.8%
Reasons for non-contact						
Interviewer ill/away	8		15		23	
Patient self-discharge	1		3		4	
		RESPONSE RATE		RESPONSE RATE		RESPONSE RATE
INTERVIEWED	50	80.6%	50	84.7%	100	82.6%
Reasons for non-interview						
Patient refused	4		3		7	
Patient never at home when interviewer called	4		2		6	
Other person refused on patient's behalf	1		2		3	
Patient would not co-operate/complete interview	1		1		2	
Patient had inadequate English	1		0		1	
Patient a friend of interviewer	1		0		1	
Missed by interviewer	0		1		1	

within the boundaries of the study areas, aged between 16 and 65 years and not admitted as a result of an accident (both patient and doctor agreeing) were approached for inclusion in the study. Two patients originally approached (one from a LRA, one from the HRA) denied that they had deliberately taken an overdose and there was no clear evidence (either toxicological or eye-witness) to the contrary. Accordingly, they were counted as accidental and do not figure in Table 5.4. An eligible patient was approached during the morning following admission, provided that she/he was in a sufficiently good physical state. I missed four patients who were admitted during the afternoon or evening and discharged themselves against medical advice the same night.

I told patients that I was not a member of staff or involved in treatment in any way, but present in the ward in order to carry out a research project. I explained that I was interested in finding out more about the sequence of events leading to their admission to the RPTC, and about their opinions and attitudes on a number of issues which related to their local area. Where necessary, I reassured the patient that he or she had been approached only by virtue of his/her address and a first-time appearance on the ward, and not for any reasons connnected with the patient him/herself or the parasuicidal episode per se. Once the patient agreed to take part in the study, I arranged an interview a couple of days ahead. The delay was considered prudent because of the likely drug effects upon cognitive and intellectual processes in the immediate aftermath of the overdose (Eastwood et al., 1972). In view of the lack of privacy on the ward I also tried to arrange to see the patient at home (most patients being discharged within two days of admission to the RPTC). Some patients did not want to be interviewed elsewhere, either

because they did not want me to visit their home, or because they had no time, or for other reasons. In these cases I carried out an interivew on the ward, wherever possible in a private ante-room. Table 5.5 shows that nearly three-quarters of all interviews with patients were carried out in their own homes. The differences between groups were not statistically significant. The mean number of days which elapsed between admission and interview was 5.18 in the LRA sample and 6.36 in the HRA sample ($T = -1.18$, $p>.2$). I continued taking patients into the study until I achieved a sample of 50 completed interviews from each area. The response rate achieved was 82.6% overall, 80.6% in the LRA and 84.7% in the HRA. Seven patients refused an interview, six patients were never found at home (although each was visited on at least six occasions) and a further eight were missed for a variety of reasons (see Table 5.4).

The representativeness of the achieved (interviewed) sample (N = 100) was assessed by comparing it to the sample of non-interviewed patients (N = 48) on a number of social, demographic and clinical variables. (The instrument used can be found in Appendix 5.1.) The proportion of the total initial sample which was interviewed or missed was calculated for each category of every variable. The significance of any differences was assessed by χ^2 test for the LRA and HRA separately. Out of 40 variables available for analysis the achieved sample in the LRA was found to be representative of the initial sample on all but three variables, namely, civil state, coma level and source of principal drugs used. Fifty-eight per cent of single patients were interviewed compared to 73% of married and 83% of separated/divorced patients ($\chi^2 = 6.47$, 2 d.f., $p<.05$). Only 63% of patients admitted in a fully conscious state (grade zero) were interviewed compared to 94% of patients

Table 5.5 Location of research interview

Location	LRA	HRA	Total
Patients			
Patient's home	39	34	73
RPTC	5	8	13
Psychiatric hospital	2	5	7
Other	4	3	7
Controls			
Control's home	50	50	100

admitted with some degree of unconsciousness (χ^2 = 4.45, 1 d.f., p<.Ø5). Finally, 5Ø% of patients who had ingested non-prescribed or illegally obtained drugs were interviewed compared to 78% of patients who had overdosed on prescribed medication (χ^2 = 7.39, 2 d.f., p<.Ø5). There were only two variables on which the HRA achieved sample was unrepresentative: social class and time in present job (employment status). Eighty-four per cent of patients in classes I and II were interviewed, compared to 81% in class III, 77% in class IV and 5Ø% in class V (χ^2 = 17.8Ø, 7 d.f., p<.Ø2). And whereas 81% of employed patients were interviewed, only 51% of those unemployed were in the achieved sample (χ^2 = 1Ø.72, 3 d.f., p<.Ø2). The implications of these findings for the interpretation of patient-control differences on cultural measures are discussed in Chapter 8.

5.2.2 Selection of control sample

In accordance with the study design, each patient was to be matched with a general population control by sex, age (± 2 years) and area of residence (within a quarter of a mile). Two possible sampling frames for the control sample were considered: the electoral register and the general practitioner age-sex register. Both methods have their advantages and disadvantages.

Although the electoral register gives a virtually complete coverage of all 18 year olds and older plus a certain number of 17 year olds at the time of registration, it is already somewhat inaccurate by the date of its publication. With every passing month this inaccuracy increases, since newcomers to the area will not be recorded and those who have left the area will still appear on the list. It was for this very reason of inefficiency that Cochrane and

Robertson (1975) abandoned the idea of using the electoral register as a sampling frame in their study of stress and parasuicide. Furthermore, the omission or incomplete coverage of under 18 year olds in the electoral register would necessitate the use of alternative sources of information in order to match patients aged 16 or 17. Another disadvantage about using the electoral register is that it lacks information about age. While it is usually possible to identify the person's sex (although some first names are used by both sexes and sex has to be inferred from the first name), age can only be discovered by making inquiries of the person listed. Adopting this procedure not only entails a considerable waste of time until a correct match is found, but - more importantly - means that the researcher has to present himself without prior notice to "sell" the project to an often suspicious respondent. I felt strongly that the likelihood of co-operation from members of the public in certain areas of Edinburgh would be severely jeopardised unless my bona fides could be established beforehand, preferably by means of an introduction from someone known to the respondent, especially his/her general practitioner.

The major advantage of securing permission to use the general practitioner's age-sex register as a sampling frame is precisely that the researcher is also likely to obtain an endorsement of the research project from the G.P. and thus ensure a reasonable response rate from the target respondent population. Also, of course, age and sex and address can be precisely identified, curtailing the amount of time spent in identifying the correct matched control. There is no problem about coverage of 16 and 17 year olds. However, there are some difficulties with this method.

Four years after the inception of the National Health Service (NHS), Gray and Cartwright (1953) found that all but 2-3% of a random sample of over 7000 adults in England and Wales were registered with a general practitioner under the NHS. They also showed that perhaps half of the sample in some way choose their doctor. Therefore, it cannot be concluded from their findings that 97-98% of the general population in a particular geographical area is covered by practices in the same area, since residents may be registered elsewhere. Sampling an area population by practices within the area means that residents registered with doctors outside the area cannot enter the sample and may be atypical (Kennedy, 1971: 63). Screening all practices within a city to ensure full coverage of one area's population is neither feasible nor practical. It should also be noted that, in Edinburgh at any rate, only a minority of the population are registered with practices which keep an age-sex register (or some equivalent). A final drawback about using the age-sex register - where it is available - as a sampling frame is that newcomers to the area are probably under-represented (since they are less likely to have registered than long-term residents), while a number of people who move out of the area will not inform their doctor and will continue to be recorded as living at their old address until they re-register with another doctor. Thus, in areas of high mobility, the registered general practice population is likely to be a less comprehensive and representative sampling frame than in areas of low social mobility.

After consideration of the relative merits and demerits of each method, I decided to use the age-sex register as the sampling frame, provided that the areas where I would be seeking controls were adequately covered by an age-sex register (or some equivalent). Both

methods were likely to be somewhat inefficient and entail a considerable degree of non-contact, but use of the age-sex register would enable easy coverage of 16 and 17 year olds, would be far less time-consuming in identifying controls and would hopefully lead to an appreciably higher response rate. Table 5.6 shows that only one practice in Newington, Pilton, Murrayfield/Cramond, and two practices in Corstorphine maintained some form of age-sex register. Enquiries also revealed that the population of each study area fell within the catchment area of one or more of these practices. The practice in Pilton with nine partners (ten during the course of the study) was situated at the centre of the ward; the boundaries of its catchment area were virtually identical to those of the ward. Two practices with eleven doctors (thirteen during the course of the study) were located in the same building towards the centre of the Corstorphine ward. Their catchment areas were similar, covering the whole of the ward of Corstorphine plus the southern part of the Murrayfield/Cramond ward. The northern and central section of Murrayfield/Cramond was covered by one practice with six partners (ten during the course of the study). Finally, one practice in Newington (four partners), although situated at the west end of the ward, covered the whole of the area, its catchment zone extending beyond the ward's eastern boundary.

Following the identification of the five 'target' practices, a letter was sent to the senior partner of each practice, outlining the proposed research project, requesting access to the age-sex register, and suggesting a personal meeting to discuss the project in detail. At the same time I sought and received approval for the project from the General Practitioner Sub-Committee of the Lothian Area Medical Committee.

Table5.6 Distribution of General Practitioners and General Practices in the four study areas

Area	General Practitioners			General Practices		
	Total N during course of study	N using ASR* or equivalent	N used in the study	Total N	N using ASR or equivalent	N used in the study
Newington	9	4 (4)	4	6	1	1
Corstorphine	19	13 (11)	13	4	2	2
Murrayfield/ Cramond	21	10 (7)	10	5	1	1
Pilton	11	10 (8)	10	2	1	1
TOTALS	60	37 (30)	37	17	5	5

* The average number of doctors at any point in time is given in parentheses

(ASR = Age/Sex Register)

At separate meetings with each senior partner, the project was fully described. Particular emphasis was given to the following points. Firstly, all the practical work of identifying the controls would be done by myself; no major demands would be made on the time of any of the members of the general practice team. Secondly, the approach to controls would be made by the appropriate G.P. who would sign a duplicated letter, outlining and supporting the project and introducing me to the recipient. I stressed that this approach was considered necessary in order to achieve the highest possible response rate. Thirdly, it was made clear that no control would be approached unless approval to do so had been given by his/her G.P. However, I also put forward the hope that refusal to allow an approach to the control would be exceptional, and suggested that any such refusal should be discussed to ensure comparability of criteria between different doctors and practices. At the same meeting I asked for information about the nature of the age-sex register. I wanted to discover whether there were any practical problems concerning its use. Subsequently, all five practices gave their approval to the project, consented to the use of their age-sex register and agreed to the wording of the letter to the controls.

Because of inter-practice differences in organisation of the age-sex register and lack of fit between ward boundaries and the practice catchment areas, it was necessary to adopt slightly different matching procedures depending on the address of the patient to be matched. All controls to match patients in the HRA were to be obtained from a single practice, which employs a Family Register, rather than the conventional age-sex register. Selected data (including age, sex, address) on each family (based on a household

unit) are recorded on one loose-leaf sheet. The entries (sheets) are filed alphabetically and can be found in one of 56 books of the Family Register. For each control a book and a starting point within the book was chosen at random (using a table of random numbers) and every person listed from that point was checked until I arrived at the first who was the same sex and age (± 2 years) as the patient to be matched, and lived within a quarter of a mile of the patient. Then the search was continued until a second name was obtained. (I always sought a second name because of the possibility of non-contact with, or non-response from, the first.) Where the second choice control was also unobtainable or refused an interview, then I recommenced the search at the first entry after his or her name and continued in this manner until an interview was finally achieved.

Four practices were used in the LRA. The Newington practice used two conventional age-sex registers, one for the patients of one partner, the other for the patients of the remaining three partners. In accordance with the difference in numbers of patients listed in the two registers, I sampled two cases from the three-doctor register for every case from the smaller register. Dealing only with controls of the same sex as the patient, I started with those born in the same year as the patient. If nobody was found who lived within the required distance of the patient (quarter of a mile) I sought first through the names of those born one year before or after the patient and then through the names of those born two years before or after, until a suitable control appeared. A second (or subsequent) choice was obtained in the same manner.

I have already noted that two practices were used in Corstorphine. Their catchment areas covered the southern part of

Murrayfield/Cramond as well as Corstorphine itself. Since some patients officially resident in Murrayfield/Cramond lived in the catchment area covered by the Corstorphine practices, controls were sought from these practices for these patients also. Both practices used conventional age-sex registers and had a similar number on the books. I therefore used each register alternatively for each new control who was sought. The same procedure for locating controls was followed as in the Newington practice. Finally, the practice surveyed in Murrayfield/Cramond did not use an age-sex register as such, but a recent computer printout of all registered patients, listed alphabetically. Information on age, sex and address was included for each patient. For each match to be obtained, a page in the printout was chosen at random and search made until I located the first person of the same sex, age (within two years) and location (within quarter of a mile) as the patient. A second (or subsequent) name was obtained in the same manner. Nineteen controls were obtained from the Newington practice, 23 from the two Corstorphine practices and 8 from the Murrayfield/Cramond practice.

For practical reasons I waited until I had interviewed three or four parasuicide patients living in the catchment of one particular practice before I looked for matching controls. However, there was never more than three months delay between the interview of the patient and the matching control.

A few days after the G.P.'s letter had been sent, I visited the control, introduced myself, answered any questions about the research project and attempted to arrange a suitable date and time for the interview, hopefully within a few days. In my explanation about the purpose of the research, I did not refer to my interest in para-

suicide. I presented the survey as an effort to gain a better understanding of people's beliefs and values concerning different problems they might face and different ways that others around them might behave. I felt that any explicit mention of parasuicide ("attempted suicide", "overdosing", etc.) could have led to a higher refusal rate or encouraged a "mental set" which might adversely affect the reliability and validity of the interview. The emphasis upon parasuicide did, of course, become evident during the interview, and as a matter of routine every control was given a fuller description of the project at the end of the interview, together with an explanation for omitting any mention of (para)suicide in the letter from the G.P. This strategy was made known to the local Medical Committee and to the collaborating general practitioners. No complaints were received from G.P.s or interviewed controls at any time during the course of the study. My general impression was that controls found my reasons for failing to make explicit reference to suicide both understandable and commonsensical rather than underhand or devious.

Table 5.7 gives details of the contact and response rates in the two area-types. The contact rate overall was somewhat disappointing at just under 70%, with the HRA showing a (nonsignificantly) lower rate due to the high number of controls not found at the address. In only 6 cases in all was I refused permission to approach a control. The response rate was a more healthy 87.7%, again (nonsignificantly) lower in the HRA. Ten controls refused to be interviewed in the HRA, four in the LRA.

The representativeness of the control populations is difficult to assess. They are not, of course, random samples: their age and sex structure is dependent upon the age and sex of individual para-

Table 5.7 Contact and Response rate for control sample, by area

Reasons for non-contact and non-interview	LRA		HRA		TOTAL	
	N	Contact/ Response Rate	N	Contact/ Response Rate	N	Contact/ Response Rate
INITIAL SAMPLE	72		91		163	
		CONTACT RATE		CONTACT RATE		CONTACT RATE
CONTACTED	54	75.0%	60	65.9%	114	69.9%
Reasons for non-contact						
Control not at address	14		29		43	
Doctor refused permission	4		2		6	
		RESPONSE RATE		RESPONSE RATE		RESPONSE RAT
INTERVIEWED	50	92.6%	50	83.3%	100	87.7%
Reasons for non-interview						
Control refused	4		10		14	

suicide subjects to whom controls are matched. Taking into consideration the fact that many other social, demographic and personal characteristics are associated with the variables age and sex, it was hoped that the control groups would otherwise be representative of the area population from which they were sampled. Two separate issues are involved here. Firstly, if I collected another 50 matched controls in each area from the same sampling frame (i.e. the age-sex register), would I find the same group profile on other variables besides age and sex (which are fixed)? Secondly, if I was able to sample from the total adult population living in the area, would I achieve the same group profile on these other variables? The latter question cannot be answered with any precision. However, following extensive use of the age-sex registers and discussion with administrators and other reception staff, I am confident that persons registered at the five practices are representative of all age groups within their particular area. The practices also seemed equally efficient in administration, so that although those recently moved to the area may be under-represented in the practice population, each age-sex register would be affected in a similar manner. (Since the Murrayfield/Cramond practice register was about six months out of date I had to supplement this source with a list of recently registered patients.) Furthermore, in four practices I could find no evidence to suggest that patients from any one social class or geographical area within the ward were missing to a significant degree.

The exception was the Newington practice, where it was appreciably more difficult to find matching controls for parasuicide subjects living in the east of the ward. In fact, adequate matching was achieved for all parasuicide subjects with addresses in the

ward. Those living in the east of the ward were found controls as well matched on the variables of age and distance from patient as those living in the west and centre of the ward. Nevertheless, it appeared that residents living in the east were less likely to register with the practice than those living elsewhere in the ward. It was therefore hypothesised that such patients might be more unrepresentative of the local population than patients living in the west and central parts of the ward. In particular, their social class position might be higher than their neighbours, since they chose to register with a practice with a predominantly middle class clientele situated in a solidly middle class district rather than with any number of alternative practices closer to home, the bulk of whose patients would be more working class. In order to make some (albeit indirect) test of this hypothesis, I compared the social class matching of the parasuicide subjects and controls living in the Newington area. Table 5.8 shows that while all nonmanual patients were correctly matched, six of the seven patients assigned to one of the manual social classes were matched with nonmanual controls. The difference between matched pairs on this variable was significant ($p = .Ø32$). To confirm the hypothesis it would be necessary to show that there was some relationship between mismatching on the social class variable and distance (eastwards) from the surgery to the control's address. Those living furthest from the surgery would be expected to show the most mismatching on this variable. This should be especially evident in the case of controls for working class parasuicide subjects. However, I found that when the Newington control sample was divided into two groups according to social class matching (twelve matched to within one class of the patient, seven mismatched by at least two social classes) the mean distance from home address to surgery was identical

Table 5.8 Matching of patients and controls by social class (Newington practice only)

		SOCIAL CLASS OF CONTROL	
		Nonmanual	Manual
SOCIAL CLASS OF PATIENT	Nonmanual	12	0
	Manual	6	1

p = .032 (Binomial Test, 2 tail)

(approximately five-eighths of a mile) in both groups. Three of the seven most mismatched controls lived less than five-eighths of a mile from the surgery, while four lived over five-eighths of a mile away. Omitting the one mismatched nonmanual patient and control, then two of six controls most mismatched to manual parasuicide patients lived close by while four lived further away (a nonsignificant difference.) While accepting that this in no way constitutes a fully adequate test of the representativeness of the Newington age-sex register, I would cautiously conclude that the practice population living in the east side of the ward is no less representative than the practice population on the west/central side, at least in relation to social class position.

Unfortunately, while it is possible to make some rudimentary assessment of the difficulties involved in using the age-sex register as a representative sampling frame, the problem of testing the adequacy of the achieved (interviewed) sample is insurmountable. This is mainly because information is lacking on non-contacts or non-respondents (except, of course, for age, sex and address). No matter how many control names are obtained as a match for a particular patient, each will always be the same sex and age ($\pm$ 2 years) as, and live within a quarter of a mile of, the patient. There might be differences on other sociological variables such as social class or marital status, or on personality variables, but this possibility is not open to proof.

Chapter 6 INSTRUMENTS

6.1 Introduction

Table 6.1 outlines the content of the various schedules and questionnaires which were used in the course of the research interview. Four instruments were intended to test middle-order hypotheses (see Chapter 4) relating to specific elements of the cultural system (see Chapter 2). Thus, the Value Orientation Schedule (VOS) operationalises the more abstract, general dimension of the value complex and permits comparison between area groups on time orientation, conceptions of human nature, etc. The Ways of Behaving Instrument (WOBI), derived from Gibbs' conceptualisation of norms (Gibbs, 1965) is designed to provide empirical measures of normative evaluations and expectations of behaviour. Items coverted relate to suicidal behaviour and other "officially" deviant acts, including behaviours which allegedly differentiate working class from other class subcultures and reflect a life pattern which is conducive to parasuicide. The Case Vignette Instrument (CVI) has been expressly devised to capture the cognitive, affective and moral evaluations of parasuicide. In view of the fact that the subcultural perspective has tended to focus above all upon the normative status of parasuicidal behaviour (to the exclusion of the wider normative system), this instrument arguably possesses the greatest potential significance of all those used in the study. The Contact with Suicidal Behaviour (CSB) schedule measures the extent, quality and type of lifetime encounters with different forms of suicidal behaviour. It is particularly relevant to an evaluation of the importance of role-modelling in the HRA. The purposes of the

Table 6.1 Instruments used in the research interview

Instruments (in usual order of administration)	Content
1. Background Data Schedule (BDS)	Social and demographic information; Community attitudes and sentiment; Local bonds; aspects of the parasuicidal episode*
2. Value Orientation Schedule (VOS)	Underlying assumptions about our relationship to our environment: evaluation of five common human problems for which people must find some solution
3. Ways of Behaving Instrument (WOBI)	Selected aspects of the normative system: community evaluations and expectations with respect to specific modes of behaviour, including suicide and parasuicide
4. Case Vignette Instrument (CVI)	Perceptions, definitions and evaluations of parasuicidal behaviour, as described in case vignettes
5. Contact with Suicidal Behaviour (CSB)	Lifetime contact with different forms of suicidal behaviour; personal involvement, relationship to (para)suicidal individual
6. Psychological Wellbeing Scale (PWB) (every 5th subject only)	Avowed happiness or feeling of psychological wellbeing

* These data are not included in the present work

remaining two instruments (Background Data Schedule and Psychological Wellbeing Scale) are described below.

Information necessary to complete Instruments 1 and 5 was sought by the interviewer, while it was intended that Instruments 2, 3 and 4 should always be completed by the respondent. However, seven parasuicides and one control were unable to fill in at least one of these instruments for a variety of reasons, including near-illiteracy, lack of spectacles, and inability to concentrate. On these occasions the interviewer read through the instruments and noted down the respondent's answer on each item. The problems created by this procedure differed with each instrument and are noted in the relevant section below.

All interviews were administered by the author and lasted on average 60-75 minutes in the case of controls and 75-90 minutes in the case of parasuicides. For the main study, each respondent was interviewed only once. However, in order to assess the stability of responses on the various instruments, I decided to re-interview every fifth patient incepted into the study and his/her matching control. The time between interviews was to be about twelve weeks. Instruments 2, 3 and 4 were completed afresh by all re-interviewed respondents. The re-interviewed sub-sample were also administered Instrument 6 (Bradburn's PWB scale) on both occasions. The second interview was always carried out at the respondent's home and rarely took more than one hour. Although all forty subjects agreed to a subsequent interivew, only 35 were successfully followed-up. Two patients in the LRA area refused; one patient in the HRA refused and one could not be traced; and one control in the HRA refused. Table 6.2 shows that the mean number of days between interviews was 76.8,

Table 6.2 Number of days between interviews in follow-up sample

Area	Patient or Control	N	Mean n. days between interviews (S.D.)		Significance of difference
LRA	P	8	77.6	(18.8)	ns
HRA	P	8	73.5	(11.3)	
LRA	C	10	80.0	(25.3)	ns
HRA	C	9	75.4	(11.6)	

There were no significant differences between control or patient groups. In order to test for significant differences within each area-type, it was necessary to use matched pairs of patients and controls. There were eight matched pairs in the LRA and seven in the HRA. The data was as follows:

Area/Group	N matched pairs	Mean n. days between interviews (S.D.)		Significance of difference
LRA				
Patient	8	77.6	(18.8)	ns
Control		83.9	(26.4)	
HRA				
Patient	7	78.9	(13.5)	ns
Control		75.9	(14.0)	

with no significant differences between patient or control groups, or within either area-type. Detailed results on the outcome of the follow-up interview as an indicator of instrument stability will be reported separately for each instrument. The various instruments used in the study and their psychometric properties are now described.

6.2 Background Data Schedule (BDS)

The BDS was basically concerned with eliciting social and demographic information on the respondent and his household, e.g. sex, age, marital status, birthplace, social class, religion, household composition, etc. (see Appendix 6.1). (The BDS also included questions on aspects of the parasuicidal episode. These data are not reported in the thesis.) In addition, there was a series of questions (based on work by Kasarda and Janowitz, 1974) designed to permit the construction of scales measuring community attitudes and sentiments, and local social bonds. These variables are listed in Tables 6.3 and 6.4 (see also Appendix 6.1), which set out the distribution of responses for each area-type x status group and provide evidence for their acceptability as Guttman scales. The Community Sentiment Scale is, as the name suggests, a measure of felt attitudes towards the neighbourhood and immediate social environment. It is constructed in order to gain some understanding of residents' feelings of belonging or marginality, and to provide subjective evidence relative to the characterisation of the HRA as a "defeated neighbourhood" (Suttles, 1972; see Chapter 9). The Local Bonds Scale, which measures friendship and kinship ties within the local community, is particularly relevant to the discussion on subcultural transmission of values and norms in the HRA (see Chapter 9).

Table 6.3 Community Sentiment Scale: distribution of responses by area-type and group, and psychometric properties

Scale score*	LRA				HRA				TOTAL	
	Patients		Controls		Patients		Controls			
	N	(%)	N	(%)	N	(%)	N	(%)	N	%
0	3	(6)	0	(0)	8	(16)	8	(16)	19	(8.5)
1	6	(12)	4	(8)	11	(22)	10	(20)	31	(15.5)
2	7	(14)	5	(10)	8	(16)	12	(24)	32	(16.0)
3	23	(46)	18	(36)	14	(28)	12	(24)	67	(33.5)
4	11	(22)	23	(46)	9	(18)	8	(16)	51	(25.5)
	50	(100)	50	(100)	50	(100)	50	(100)	200	(100.0)

Coefficient of reproducibility = .9025

Minimum marginal reproducibility = .7200

Percent improvement = .1825

Coefficient of scalability = .6518

* The four items used to construct the scale were: HOMEFEEL (rated 1); PRESFEEL (rated 1 or 2); MOVEPLAN (rated 0, 1 or 7); MOVEFEEL (rated 1 or 2). (See Appendix 6.1 for copy of BDS and description of variables.)

Table 6.4 Local Bonds Scale: distribution of responses by area-type and group, and psychometric properties

Scale score*	LRA				HRA				TOTAL	
	Patients		Controls		Patients		Controls			
	N	(%)	N	(%)	N	(%)	N	(%)	N	%
0	1	(2)	0	(0)	1	(2)	1	(2)	3	(1.5)
1	28	(56)	30	(60)	16	(32)	5	(10)	79	(39.5)
2	20	(40)	17	(34)	23	(46)	35	(70)	95	(47.5)
3	1	(2)	3	(6)	10	(20)	9	(18)	23	(11.5)
	50	(100)	50	(100)	50	(100)	50	(100)	200	(100)

Coefficient of reproducibility = .9200

Minimum marginal reproducibility = .7533

Percent improvement = .1667

Coefficient of scalability = .6757

* The items used to construct the scale were: AREAPEOP (rated 1 or 2); AREAFRND (rated 3 or more); AREAREL (rated 1 or more). (See Appendix 6.1 for copy of BDS and description of variables.)

Unfortunately, there is no means of checking the accuracy of factual information given by controls. In the case of patients, however, data relating to a number of socio-demographic variables are also available from the RPTC coding sheets which are routinely completed for each admission (see Appendix 5.1). I have made a comparison of findings using these different sources, although it is not clear whether this exercise constitutes a validity check or a test of reliability. In the case of the RPTC, the patient is questioned by a psychiatrist who either makes a direct rating him/herself or writes information (e.g. on social class) which is later rated by a clerk. The completed coding sheet is then checked further by MRC staff. It should also be noted that at least four psychiatrists are involved in the collection of data over a twelve month period. In my study (SP), I collected all the data direct from the patient. I also coded and checked it myself. The RPTC coding sheet is completed on the ward usually within one day of admission, whereas in my study the mean N of days from admission to interview was 6 days and the majority of interviews were carried out in the patient's home. Thus, the RPTC-SP comparison can be seen as a measure of inter-rater reliability and/or test-retest reliability or of validity. The difficulty with conceptualising the comparison as a test of validity is that neither data base (RPTC or SP) can be said a priori to constitute the criterion or standard against which the accuracy of the other is assessed. However, the following analysis will demonstrate that, in general, the SP ratings are far more likely to be "correct" than the RPTC ratings.

The variables for which comparative information is available are: sex, age, civil state, household composition, overcrowding,

employment status and social class. Only in the case of age and sex were data from the two sources directly comparable. For the other eight variables, I have made alterations or amendments to my own coding scheme in order to ensure comparability with the RPTC coding sheet (for the purpose of this analysis only). Thus, all disagreements between the two sources constitute substantive findings which require explanation.

On the variable sex there was only one disagreement between RPTC and SP ratings. There were twelve discrepant cases on the variable age (in eleven cases there was a difference of one year, in one case a difference of two years). In ten cases the two data sets agree on date of birth but the RPTC calculation of age is in error. In two cases there is disagreement on date of birth and it is not possible to resolve which date, if either, is correct. There are eleven disagreements between RPTC and SP ratings on the patient's civil state: one appears to be explained by a different time reference in the two data sets (the RPTC rating relating to the time of interview, whereas the SP rating relates to the time just prior to the parasuicide); one is due to error by SP; one could be due to error by either source; the rest (eight) are due to RPTC coding errors. On the variable household composition there are sixteen disagreements, of which eleven appear to be caused by RPTC error; one is due to error by SP; one arises out of a difference in coding Hall of Residence (SP codes under "Institution", RPTC under "Alone"); and three seem to relate to a differing time reference (see above). Eight of the ten disagreements concerning overcrowding in the patient's household appear to be due to RPTC error (including two cases rated "not applicable" which seem, in fact, to be applicable); in one case the disagreement concerns the point in time to which the

rating refers; and in the last case the disagreement hinges on the definition of a "room". There are eleven disagreements concerning the patient's employment status. In two cases the RPTC rating is "Not Known". Two disagreements are based on fundamental differences in rating the status of married women who are not in paid employment outside the home. Four discrepancies are based on differing classification of invalidity pension: SP codes as "retired", RPTC as "unemployed". Two RPTC ratings are probable errors, while the final disagreement cannot be resolved without further independent evidence. The final sociodemographic variable for which information is available from both sources is the patient's social class rating. Table 6.5 shows the extent of disagreement (35 cases out of 100). Eleven disagreements were due to misuse of the "No usual occupation" rating by RPTC; for SP there were no such cases in the sample. In one case the RPTC rated "Not Known". For the remaining 23 patients there was substantive disagreement on the actual social class rating. Nineteen such cases were clearly due to errors by RPTC, including miscoding of occupation (nine cases), inadequate description of occupation (six cases), rating of married woman's own occupation, not husband's (three cases) and rating of previous employment, not current job (one case). Two disagreements were due to error by SP, in one case SP and RPTC listed different occupations and in the final case the rules for coding were not strictly comparable. Overall, 31 of the 35 disagreements were almost certainly due to RPTC error and only two to SP error.

This analysis shows that for seven socio-demographic variables the extent of disagreement ranged from 1% to 35%. However, it has also been demonstrated that virtually all the disagreement is caused by errors in the RPTC data set. The reliability and validity of the

Table 6.5. Agreement between author and RPTC on patient's social class rating

RPTC rating of social class	Author's rating of social class							TOTALS
	I	II	IIINM	IIIM	IV	V	Student	
No usual occupation	0	0	3	4	1	3	0	11
I	2	0	0	0	0	0	0	2
II	1	11	1	1	0	0	0	14
IIINM	0	0	14	4	1	0	0	19
IIIM	1	2	1	12	1	3	0	20
IV	0	0	1	2	17	1	0	21
V	0	0	1	0	2	3	0	6
Student	0	0	0	0	0	0	6	6
NK	0	0	0	0	1	0	0	1
TOTALS	4	13	21	23	23	10	6	100

Overall agreement = 65%

data collected by the author, at least in relation to these seven variables, is considered to be acceptable for the purposes of this study. (The few errors in the author's data which were definitely uncovered in the course of this analysis were duly corrected. The data reported throughout this thesis relating to the BDS incorporate these corrections.)

6.3 Value Orientation Schedule (VOS)

6.3.1 Description

This instrument is a modified version of the schedule devised by Kluckhohn and Strodtbeck for use in the Rimrock studies (Kluckhohn and Strodtbeck, 1961) and designed to measure group value orientations. As we have seen (Chapter 2), value-orientations are a sub-category of the more general sociological concept, values; they refer to the most general, least articulated dimension of the value complex. They are our underlying assumptions and evaluations about our relationship to our environment - physical, temporal, social and spiritual. Kluckhohn and Strodtbeck define a value orientation as "a generalized and organized principle concerning basic human problems which pervasively and profoundly influences man's behavior." (Kluckhohn and Strodtbeck, 1961: 341). More specifically: "Value orientations are complex but definitely patterned (rank-ordered) principles, resulting from the transcultural interplay of three analytically distinguishable elements of the evaluative process - the cognitive, the affective, and the directive elements - which give order and direction to the ever-flowing stream of human acts and thoughts as these relate to the solution of 'common human' problems." (Kluckhohn and Strodtbeck, 1961: 4).

Three major assumptions underlie their classification of value orientations. The first is that there is a limited number of common human problems for which all people at all times must find some solution. Secondly, while there is variability in solutions of all the problems, it is neither limitless nor random, but is definitely variable within a limited range of possible solutions. The third assumption is that all variations of recurring solutions are present in all societies at all times but receive, from one subculture to another, varying degrees of emphasis. It therefore follows that the differences between value-orientation systems of distinctive cultures or sub-cultures are not absolute, but variations of the same components which are common to all cultures at all times.

To date, five problems have been identified by Kluckhohn and Strodtbeck for which people in any society must find solutions. These problems concern the nature of man himself, his relation to nature and supernature, his place in the flow of time, the modality of human activity, and the relationship man has with his fellow human beings. The names given to these value orientations are, respectively, human nature, man-nature, time, activity and relational (Kluckhohn and Strodtbeck, 1961: 10-20, 340-4). With one exception, Kluckhohn and Strodtbeck postulate that there are three solutions (six in the case of human nature) to each common problem being considered, and that, though all solutions are always present, the order in which they are emphasised may vary between groups, social classes, societies, etc.

In the case of the Human Nature orientation Kluckhohn and Strodtbeck offer three logical divisions of Evil, Good and Evil, and

Good. The concept of innate human nature as Good and Evil may be more logically divided into two separate categories, for a significant difference exists between a view of human nature as simply neutral and a view of it as a mixture of Good and Evil. Further, the sub-principles of mutability and immutability increase the basic classification of alternatives within this value orientation to six. The three alternatives in Man-Nature orientation are Subjugation-to-Nature, Harmony-with-Nature and Mastery-over-Nature. The Subjugation-to-Nature alternative gives a feeling of fatalism; there is little man can do about such problems as fire, storm and illness except to accept them as inevitable. In the Harmony-with-Nature alternative there is no real separation between man and nature, and a sense of completeness and well-being derives from their unity. In the Mastery-over-Nature alternative, natural and social forces of all kinds are to be overcome; the weather is to be controlled, length of life is to be prolonged, business failure to be avoided.

The three alternatives in the Time value-orientation are Present, Past and Future. These terms scarcely need elaboration: no society can or does ignore any of the time periods, though they may of course differ with regard to which of the dimensions is dominant. Kluckhohn and Strodtbeck illustrate the ordering of these alternatives by noting that Spanish Americans emphasise the Present, Chinese (in earlier historical periods) emphasised the Past, and Americans emphasise the Future (p 14-15). The alternatives for the Human Activity value orientations are: Being, Being-in-Becoming, and Doing. The range of variation of the three alternatives is intended to centre solely on the problem of the nature of man's mode of self-expression in activity. The Being alternative expresses a

preference for the kind of activity which is a spontaneous expression of what is conceived to be "given" in the human personality. It puts stress on a relatively spontaneous, non-developmental conception of activity. The Being-in-Becoming alternative shares with the Being alternative a great concern with what the human being is, rather than with what he can acomplish. However, in this alternative the idea of the development of an integrated self is paramount. The Being-in-Becoming alternative emphasises activity which has as its goal the development of all aspects of the self as an integrated whole. The Doing alternative demands a kind of activity which results in accomplishments that are measurable by standards conceived to be external to the acting individual, i.e. an objectively measurable accomplishment.

The Relational orientation has three alternatives: Individualistic, Collateral and Lineal. Individualism is rooted in the uniqueness (whether physical, psychological, or cultural) which each person has when compared with another. Practically speaking, an emphasis on Individualism means that each person essentially makes his own decisions and acts on these in a manner relatively independent of other persons. It signifies a determination not to surrender one's autonomy, although it may be given freely. If the individualistic principle is dominant, and the other two alternatives are interpreted in terms of it, individual goals will have primacy over the goals of either collateral or lineal groups. When the Collateral principle is dominant, the goals or welfare of the laterally extended group have primacy. The familial basis for collateral relations is found in the ties among siblings. In the exercise of power and the making of decisions, Collaterality is exhibited in a preference for general group discussion until

consensus is reached. When the Lineal principle is most heavily stressed it is again group goals which are of primary concern to individuals, but there is the additional factor that one of the most important of these goals is continuity through time, and ordered positional succession within the group. Lineal relations are those that stress the descent from father to child. In behaviour spheres other than family life, Lineal relations emphasise superior and subordinate positions in the exercise of authority.

The original Kluckhohn-Strodtbeck instrument consisted of twenty-two items divided among four value orientations (Relational - seven items; Man-Nature - five items; Time - five items; Activity - five items). The items used to measure the Relational, Man-Nature and Time orientations tested for the rank ordering of all three alternatives. Those which tested the Activity orientation sought only for preferences between Doing and Being. Limitations of time and money prevented their development of the Being-in-Becoming alternative of the Activity orientation and also precluded any consideration of the Human Nature orientation (Kluckhohn and Strodtbeck, 1961: 77). Each item of the schedule first delineated a type of life situation believed to be common to most rural or folk societies and then posed alternative solutions to the problem which derived from and gave expression to the theoretically postulated alternatives of the value orientation in question. The two principal questions put to the respondent, concerning possible alternative solutions to a "real life" situation, elicited his choice among three alternatives and then his preferences between the remaining two. The resulting ranking pattern yielded by the use of these two questions was the primary data of the research.

In the present research, the original schedule has been modified and adapted for use in an urban community. Changes were necessitated by the rural context of many of the problem situations which would have been either meaningless or irrelevant to the respondents in this investigation. However, the format of the item and alternatives closely followed Kluckhohn and Strodtbeck's theoretical scheme, and in some cases, was an actual "translation" of a concrete item in the original schedule from a rural to an urban setting. The original schedule has also been extended to include a fifth value orientation, Human Nature, which, though part of the Kluckhohn-Strodtbeck theory, was not included in their instrument. Following Schneiderman (1963), the six-point range of value orientation preferences outlined by Kluckhohn and Strodtbeck was compressed into a dichotomy suggested by Gordon (1955: 39), namely, a pessimistic as opposed to an optimistic view of human nature. "Since, as Kluckhohn has pointed out it is doubtful whether there are any societies committed to a definition of human nature as immutably Good, it seems possible to juxtapose a view of human nature that is Evil and immutable (pessimistic) against one that is Neutral, or a mixture of Good and Evil and mutable (optimistic)." (Schneiderman, 1963: 57). Gordon (1955: 38-9) notes that each of the two fundamentally different philosophical positions about the nature of man, one "essentially positive, hopeful and optimistic" while the other is "negative, discouraging and pessimistic", "leads us down a different pathway in our relationship with other individuals". Items 3, 8, 12, 15 and 23 of the present schedule were constructed, using the Kluckhohn and Strodtbeck outline for item constructions as a guide (Kluckhohn and Strodtbeck, 1961: 79), to test this orientation.

Appendix 6.3 presents in full the Value Orientation Schedule, as

used in the present study. The introductory Instructions (given in Appendix 6.2) were read out informally by the interviewer, then the Schedule was normally completed by the respondent. In eight cases where the respondent was unwilling/unable to complete the Schedule, I read out each item and its alternatives separately and noted down the response(s). Although more laborious and time-consuming, this procedure did not appear to cause undue problems. In order to ensure reasonable standardisation between interviews, I stressed that I would not be able to paraphrase or explain the alternative choices or answer any questions about the items until the Schedule had been completed.

The Key to the Schedule is provided in Table 6.6 below. From this Table it can be seen that items from the various Value Orientation areas were distributed throughout the Schedule, and within items relating to a particular orientation the three (or two) alternatives represented by the three (or two) solutions for a life situation were systematically rotated.

6.3.2 Pre-test procedures

The orignal Kluckhohn/Strodtbeck instrument was modified for use with an urban population. This first amended version contained only twenty questions, omitting all items on the Human Nature orientation, and was pre-tested on twenty parasuicide patients and ten members of staff from the RPTC. After analysing the formal response and informal comments of respondents, amendments were made to 12 of the original 20 questions. In the case of nine items (Q1, Q2, Q6, Q7, Q10, Q11, Q16, Q24 and Q25) these were minor alterations to wording, while more substantial changes were made to Q5 (alternative C

Table 6.6 Key to Value Orientation Schedule

Question No.	Value Orientation	Item No.	Alternatives A	B	C	Source
1	Activity	A1	Doing	Being	-	K + S* Item 5
2	Relational	R1	Lineal	Collateral	Individualistic	(K + S Item 2)
3	Human Nature	HN1	Pessimistic	Optimistic	-	S** Item 3
4	Time	T1	Past	Present	Future	K + S Item 3
5	Man-Nature	MN1	Subjected	Mastery	Harmony	K + S Item 13
6	Time	T2	Present	Future	Past	K + S Item 5
7	Man-Nature	MN2	Harmony	Mastery	Subjected	K + S Item 19
8	Human Nature	HN2	Optimistic	Pessimistic	-	S Item 6
9	Relational	R2	Individualistic	Collateral	Lineal	(K + S Item 7)
10	Activity	A2	Being	Doing	-	(K + S Item 18)
11	Man-Nature	MN3	Mastery	Harmony	Subjected	(K + S Item 10)
12	Human Nature	HN3	Pessimistic	Optimistic	-	S Item 12
13	Time	T3	Present	Past	Future	K + S Item 11
14	Relational	R3	Collateral	Lineal	Individualistic	(K + S Item 7)
15	Human Nature	HN4	Optimistic	Pessimistic	-	S Item 19
16	Relational	R4	Individualistic	Lineal	Collateral	K + S Item 12
17	Man-Nature	MN4	Harmony	Subjected	Mastery	K + S Item 6
18	Time	T4	Future	Present	Past	(K + S Item 14)
19	Activity	A3	Doing	Being	-	K + S Item 21
20	Man-Nature	MN5	Subjected	Harmony	Mastery	(K + S Item 4)

* Item on Kluckhohn-Strodtbeck VOS (Kluckhohn and Strodtbeck, 1961: 80-90). Considerably amended items are in brackets.
**Item on Schneiderman's amended and enlarged VOS (Schneiderman, 1963: 187-198).

Table 6.6 continued ...

21	Activity	A4	Being	Doing	-	K + S Item 22
22	Time	T5	Past	Future	Present	(K + S Item 20)
23	Human Nature	HN5	Pessimistic	Optimistic	-	S Item 23
24	Relational	R5	Lineal	Individualistic	Collateral	-
25	Activity	A5	Doing	Being	-	K + S Item 1

replaced), Q14 (throughout) and Q19 (throughout). (Question numbers refer to the final version of the VOS, as presented in Appendix 6.3.) In view of these alterations and the addition of five items on the Human Nature orientation, it was considered necessary to establish the reliability and validity of the final version of the VOS as if it were an altogether new instrument. Psychometric data on the final version of the VOS will be presented in the next two sections.

6.3.3 Reliability

Reliability of the instrument was assessed by examining test-retest stability and internal consistency. In the course of the main study using the enlarged and amended version of the VOS, 35 respondents were re-interviewed approximately eleven weeks after the first interview (see Table 6.2). On average just over 70% of the sample gave the same pattern of responses to individual items on the two occasions. However, on six items 61% or fewer respondents gave the same response. These were items A1 (Q1), HN2 (Q8), R2 (Q9), HN4 (Q15), R4 (Q16) and HN5 (Q23). Test-retest stability was also tested for each value orientation by computing dimension scores and comparing them between interviews. For each two-alternative value orientation there was one dimension, while for the three-alternative value orientations there were three dimensions, making a total of eleven altogether (see Chapter 7 for a full discussion of the computation of dimension scores). Although there were no significant differences in mean scores (analysis by paired T-Test, α = .05) on any of the value dimensions in the whole group, three dimensions showed non-significant correlations (Pearson r, 2 tail, $p>.05$) between interviews. These were the [Pessimistic, Optimistic] dimension of the Human Nature orientation, the [Collateral, Individualistic]

dimension of the Relational orientation, and the [Present, Future] dimension of the Time orientation.

Thus we find that there was some degree of instability within individuals on the Human Nature and Relational orientations, at the level of both items and dimensions. Most dimensions of the other three orientations were significantly correlated between interviews, and item stability was high. Although the low correlation between interviews on the Human Nature and Relational orientations is of some concern, it should be noted that mean scores for groups at the two interviews were not significantly different. While there is evidence of random error in the data, systematic bias has not been detected. In practice, therefore, the substantive findings reported below for these value orientations are unlikely to be unreliable, at least in respect of central tendency.

In order to rule out the possibility that any instability in the instrument might merely be a result of changes in mood state, I correlated the change in dimension scores between interview with the change in the individual's Affect Balance Scale (ABS) (Bradburn, 1969; for a description of the ABS see below). There were no significant associations. At each interview there was only one significant correlation between a value dimension score and current ABS score: the [Subjected, Mastery] dimension correlated $r = -.40$ ($p = .022$, 2 tail test) with ABS score at the first interview; and the [Doing, Being] dimension correlated $r = .38$ ($p = .028$, 2 tail test) with ABS score at the second interview. Thus, dimension scores and changes in dimension scores are essentially independent of current subjective feelings of well-being and changes in those feelings.

The consistency of responses on the VOS was also examined. A consistency score was calculated for each individual by summing the maximum number of items ranked first within each value orientation. Thus, if the Lineal alternative was ranked first on three items of the Relational orientation, while the Individualistic and Collateral orientations were ranked first on one alternative each, the consistency score for this orientation would be 3. Which particular alternative was ranked first on most alternatives was not relevant. For three-item alternatives (i.e. Relational, Time and Man-Nature) the possible range of consistency scores was 2-5, and for two-item alternatives (i.e. Activity and Human Nature), 3-5.

The results of the consistency analysis are reported in Table 6.7. Considering first the three-alternative value orientations, there was significantly more consistency (paired T-Test, $\alpha = .05$) within the Time and Man-Nature orientations than within the Relational orientation; and more consistency within the Time orientation than with the Man-Nature orientation. Comparing consistency between area x status groups, HRA patients showed significantly higher scores on the Relational orientation than their matched controls. On the Man-Nature orientation, LRA controls rated significantly higher in consistency than HRA controls. LRA controls also demonstrated significantly more consistency on the Time orientation than both their matched patients and HRA controls. There were no significant differences between any groups on the consistency scores for the Activity and Human Nature orientations.

Despite this variation in consistency between value orientations, the homogeneity within each value orientation reached

Table 6.7. Mean consistency scores* on the VOS - separately for each orientation and each area x status group

Value orientation	LRA				HRA				TOTAL (N=200)	
	Patients (N=50)		Controls (N=50)		Patients (N=50)		Controls (N=50)			
	Mean Score	(S.D.)	Mean Score	(S.D.)	Mean Score	(S.D.)	Mean Score	(S.D.)	Mean Score	(S.D.)
Relational	2.92	(0.72)	2.80	(0.70)	3.06	(0.71)	2.74	(0.57)	2.88	(0.68)
Man-Nature	3.14	(0.86)	3.28	(0.95)	3.04	(0.78)	2.90	(0.71)	3.09	(0.83)
Time	3.20	(0.73)	3.60	(0.86)	3.34	(0.92)	3.24	(0.80)	3.35	(0.84)
Activity	3.72	(0.73)	3.76	(0.77)	3.70	(0.76)	3.50	(0.68)	3.67	(0.74)
Human Nature	3.84	(0.71)	3.78	(0.74)	3.58	(0.61)	3.52	(0.76)	3.68	(0.71)

* See text for definition

the minimum acceptable level, i.e. greater than would be expected by chance alone. Nevertheless, there is evidence that the universe of items which was used to test a value orientation was neither unitary nor absolutely homogeneous. Table 6.8 lists the number of subjects in each group with a consistency score of >3 and >4. (Since the minimum possible score for the Activity and Human Nature orientations was 3, all subjects are rated >3 for these orientations.) It can be seen that although 3/4 or more of the total sample scored >3, only 14% (6% in the HRA control sample) scored >4 on the Relational orientation, the corresponding figures being 27% and 36% respectively for the Man-Nature and Time orientations.

This lack of complete consistency is not altogether surprising. Even in their sample of respondents living in small, integrated communities and using a relatively more restricted range of situations in their Value Orientation Schedule, Kluckhohn and Strodtbeck (1961) found that response to items operationalising the same value orientation were not entirely consistent. (The issue of consistency is not in fact discussed anywhere by Kluckhohn and Strodtbeck. My observation is based on a secondary analysis of their data, which are presented in Appendix 4, pp 417-436, of their book.) In my version of the Schedule the range of situations covered was wider and could not be expected to have a uniform relevance or salience to a more heterogeneous sample. While each respondent might show an overall preference for a particular configuration of alternatives for each value orientation (e.g. Future over Present over Past), this pattern would be subject to modification from a number of sources, including the nature of the concrete situations presented in the Value Orientation Schedule itself. However, it would be expected that deviations from each person's dominant profile

Table 6.8 Consistency scores* on the VOS - percent scoring ⩾3 and ⩾4, for each orientation and each area x status group

Value orientation	LRA				HRA				TOTAL (N=200)	
	Patients (N=50)		Controls (N=50)		Patients (N=50)		Controls (N=50)			
	Scoring ⩾3	(Scoring ⩾4)	Scoring ⩾3	(Scoring ⩾4)	Scoring ⩾3	(Scoring ⩾4)	Scoring ⩾3	(Scoring ⩾4)	Scoring ⩾3	(Scoring ⩾4)
Relational	37	(7)	33	(6)	40	(12)	34	(3)	144	(28)
Man-Nature	38	(16)	39	(19)	38	(12)	35	(10)	150	(54)
Time	43	(15)	47	(24)	42	(18)	43	(15)	175	(72)
Activity	50	(28)	50	(28)	50	(26)	50	(20)	200	(102)
Human Nature	50	(33)	50	(30)	50	(26)	50	(18)	200	(107)

* See text for definition

would be randomly spread over all items within a particular value orientation. If one item generated inconsistent rankings to a significantly greater degree than any other, then we could reasonably deduce that this item was not equivalent to the others and should perhaps be replaced or omitted.

The relevant analysis is presented in Table 6.9 which demonstrates that the distribution of deviant responses across items was in fact significantly different from an expected random pattern. Within each value orientation there was one extremely deviant item, accounting for between 26% and 29% of the inconsistent responses (against an expected value of 20%). These items were Item 5 in the Activity orientation (Q25), Item 3 in the Relational orientation (Q14), Item 2 in the Time orientation (Q6), Item 1 in the Man-Nature orientation (Q5) and Item 2 in the Human-Nature orientation (Q8). Analysis for patients and controls separately gave the same results as the analysis for the whole sample. To check on the impact of these inconsistent items upon the results reported below, all analyses were repeated omitting the relevant items. Any differences will be noted in the text.

6.3.4 Validity

The discriminative (predictive) validity of Kluckhohn and Strodtbeck's original Value Orientation Schedule was established on the basis of its capacity to differentiate between cultural groups as predicted by ethnographic data from a number of different sources. The feasibility of modification of this instrument, without disturbing its validity, was given support by the authors, who themselves report its successful modification for use in Japan. In

Table 6.9 Analysis of distribution of deviant (inconsistent) responses for each value orientation in the VOS (N=200)

VALUE ORIENTATION	% of deviant responses in each item (Analysis for whole sample)						χ^2*
	Item No. 1	Item No. 2	Item No. 3	Item No. 4	Item No. 5	TOTAL (N)	
ACTIVITY	Q1	Q10	Q19	Q21	Q25	100%	12.93, 4d.f.,
	15.9%	22.0%	22.0%	14.0%	26.1%	(264)	p < .02
HUMAN NATURE	Q3	Q8	Q12	Q15	Q23	99.9%	20.53, 4d.f.,
	12.7%	29.1%	16.3%	18.3%	23.5%	(251)	p < .001
MAN-NATURE	Q5	Q7	Q11	Q17	Q20	100.1%	14.75, 4d.f.,
	27.1%	14.8%	20.6%	15.2%	22.4%	(277)	p < .01
RELATIONAL	Q2	Q9	Q14	Q16	Q24	100%	10.77, 4d.f.,
	22.1%	16.6%	26.4%	17.6%	17.3%	(307)	p < .02
TIME	Q4	Q6	Q13	Q18	Q22	99.9%	15.00, 4d.f.,
	17.3%	29.2%	17.3%	17.3%	18.8%	(277)	p < .01

* χ^2 one sample-test (Siegel, 1956, pp 42-47). Expected value for each category of a particular value orientation = 20% of total N of deviant responses in that orientation.

making such a modification, the authors believe that validity can be preserved by defining a new problem situation equivalent to those contained in the original instrument. These situations are viewed as universal in type even though variable in specific content. The alternatives for each situation are held constant relative to the type of value orientation preference sought (Kluckhohn and Strodtbeck, 1961: 93). In modifying the schedule for use in Japan, one item used to test the Relational orientation was changed by altering the situation from one involving community action on construction of a well to one involving bridge building (see Caudill and Scarr, 1962). In the present research any modification (to a situation or to an alternative) considered necessary was made with a view to ensuring the equivalence of the new version with the original and minimal interference with the instrument's validity. Table 6.6 shows that of the twenty items tapping the four value orientations on Kluckhohn and Strodtbeck's version of the VOS (i.e. excluding Human Nature), 11 are identical with the original items or incorporate only minor changes in wording. Eight items present a different situation, although the nature of the problem and the alternatives offered closely follow the original. Q2 was modified in the present instrument to involve neighbourhood action on planning a housing estate in place of action on the construction of a well. Q9 and Q14 were concerned with help in misfortune, as was the original they replace, although the focus has shifted from crop failure to a fire in the home (Q9) and pregnancy outside marriage (Q14). Q10 presents differing attitudes to work among small shopkeepers rather than (as in Kluckhohn and Strodtbeck's version) farmers. Q11 keeps the original emphasis upon planting and taking care of crops, shifting the focus from the rural farm to the urban allotment. Q20 replaces an item on misfortune in a non-industrial context (livestock dying)

with misfortune in an industrial context (business bankruptcy). Q18 shifts the emphasis from innovation in religious ceremonies to innovation in family organisation and relationships. Finally, Q22 and the original item are both concerned with community planning. In this version it concerns road-building; in Kluckhohn and Strodtbeck's version, water allocation.

One item (Q24) is altogether new, although its format closely follows that of the other items which measure the Relational orientation. The subject matter (husband-wife relations) was inspired by the pronounced interpersonal aspects of parasuicidal behaviour (see Chapter 9). A further five items which test for the Human Nature orientation are not to be found in the original instrument. They are taken from Schneiderman (1963) and have reasonable face validity as tapping an inherently selfish, pessimistic view of human nature, on one hand, and a neutral/optimistic view, on the other. The form of the items follows Kluckhohn and Strodtbeck's model.

The VOS has been widely used over the past 20 years (although, apparently, not in Britain), both in its original form and considerably amended. Support for its discriminative/predictive validity has come from studies on fertility behaviour among white Protestant females in Kentucky, USA (Clifford and Ford, 1974, using a Likert-type version of the instrument); Canadian social workers and lower-middle class clients in family agencies (Turner, 1970, using an "amended" (unspecified) version); different generational groups among the Shoshone Indians (Tefft, 1968); marijuana use among American students (Green and Haymes, 1973, using a Likert-type format); students, factory workers and agricultural workers in the West Indies

(Lengermann, 1971, 1972, using an "adaptation" of the original instrument); students and parents in Hong Kong (Liu, 1966, using the Caudill-Scarr version of the VOS (Caudill and Scarr, 1962)); welfare clients in Ontario, Canada (Turner, 1964, using only the Relational items of the VOS); students and non-students in Saisi, Sulu (Stone and Nelson, 1966); Japanese students and parents (Caudill and Scarr, 1962, using a modified version of the VOS); Mexican Americans and Anglos in Texas (Chandler and Ewing, 1971, using a "considerably revised" version of Kluckhohn and Strodtbeck's instrument). Schneiderman's comparison of chronic welfare recipients and middle-class professionals (teachers and social workers) (Schneiderman, 1963, 1964) reveals no difference between the professional groups, but significant differences in the predicted direction between welfare clients and professionals on the Activity, Time and Man-Nature orientations. Although the professional group had a significant preference for the Optimistic alternative of the Human Nature value orientation, there was no significant pattern among the clients and no significant difference between professional and client groups.

There is, then, impressive evidence of the discriminative validity of the VOS. In addition, both the original and the present versions possess the added advantage of being constructed in such a way that response and acquiescence sets are extremely unlikely. Green and Haymes, using a modified version of the VOS in Likert-type format, found no relationship between their Value Orientations Questionnaire Scales and the Crowne-Marlowe Social Desirability Scale (Green and Haymes, 1973). However, a number of authors clearly remain unsatisfied about other aspects of the scale's validity. Swadesh (1972), for example, challenges the Kluckhohn-Strodtbeck

analysis of Hispanic values (Subjugation to nature, Being, Present time, Individualistic) by citing contrary findings in this field, backed up by samples from New Mexican folk poetry. He alleges that responses on the Time orientation obtained by Kluckhohn and Strodtbeck are related to the circumstances of the question rather than to the concept of time in general; other questions would elicit other responses. The same fundamental criticism is made of the questions used to tap the other value orientations. Wolfe, using the VOS as a framework for discussion, believes that there are "certain inadequacies" in "Kluckhohn's conceptual scheme". In particular: "African responses to the problem of the relationship of man and nature do not readily fit any of the 'three type solutions' suggested by Kluckhohn" (Wolfe, 1959: 606-7). He is especially doubtful of the validity of the individualistic alternative. "It is difficult to conceive how individualism, connoting isolation from others and emphasis upon the self, can logically refer to a mode of relationship in the same dimension as lineality and collaterality" (Wolfe, 1959: 612).

Rokeach contends that the VOS measures beliefs rather than values: "A person may indeed believe that man is subjugated to nature but this circumstance does not necessarily imply that he has a value for 'subjugation to nature', that he believes such a state of affairs to be desirable, or that man 'ought' to be subjugated to nature." (Rokeach, 1973: 22).

Cancian is critical of Kluckhohn and Strodtbeck's deductive strategy. She holds that their method is valid only insofar as the responses to the instrument's questions have the same meaning for both respondents and investigator. "If the responses have a

different meaning, i.e. if the subjects understand them in terms of a cognitive model that is quite different from Kluckhohn's theory, then the questionnaire can produce a very distorted picture of the normative system." (Cancian, 1974: 16). As an example, Cancian cites one of the items on the VOS (corresponding to Q6 in my version). She maintains that members of certain subcultures in the United States might interpret the alternative responses in terms of categories like political conservatism versus radicalism, instead of Past, Present and Future time orientation.

These attacks on the construct validity of the VOS require careful consideration. Rokeach's remarks merit the least attention. Both the theory underlying the VOS and the actual wording of questions asked in relation to each item of the instrument are clearly oriented towards measuring beliefs about what "should be" ("conceptions of the desirable" (Kluckhohn, 1951) or "conceived values" (Morris,1956a)) and not beliefs about what is. The distinction between belief and valuation is referred to explicitly by Kluckhohn and Strodtbeck: "Another question which was asked about some of the choice situations ... was what the respondent actually would do in the described situations in contrast to what he considered it would be best to do. The purpose of this question was to see whether respondents could or would differentiate between their actual behaviour and their value preference." (p 78). In my version of the VOS no information about actual behaviour was sought. The emphasis upon value preference was reinforced by the wording of the questions, the instruction repeated on each page of the schedule ("Remember: choose the solution(s) in the order which seems the most preferable or desirable to you") (Appendix 6.3), and the preamble given prior to the completion of the Schedule ("I would like you to

choose the solution which seems ideally the most preferable or desirable, regardless of what you or others actually do") (Appendix 6.2).

Wolfe's concern about the adequacy of the alternative "type solutions" of the Relational orientation may indeed be warranted by the available ethnographic data. However, I can find no similar criticism by other researchers who have used the VOS in different cultures, including Chandler and Ewing (1971), who failed to find a consistent pattern of differences between groups on this orientation, or Swadesh (1972), who was critical of the questions used to tap all the value orientations. Furthermore, Wolfe misunderstands the nature of the Individualistic alternative: the emphasis is not upon the individual's "isolation from others" (Wolfe) but upon his freedom to choose when to surrender his autonomy: he is "free [rather than coerced] to be like everybody else" (Kluckhohn and Strodtbeck, 1961: 23).

In this present version of the VOS an attempt was made to take account of Swadesh's criticism by ensuring a considerable degree of variation between the types of situation presented to test each value orientation. The twenty-five items cover six categories of activity or "behaviour spheres" (Kluckhohn and Strodtbeck, 1961: 28-9): the economic-occupational (seven items), the religious-philosophical (four items), the intellectual-scientific (two items), the recreational (four items), the political (two items) and the familial (six items). Table 6.10 shows that each orientation covers three or four behaviour spheres. We have already noted that there was one inconsistent item in each value orientation. However, these five items cover four behaviour spheres; the economic-occupational (A5), the recreational (HN2), the intellectual-scientific (MN1) and the familial (R3, T2). The extent of variation of behaviour spheres

Table 6.10 Items of the VOS allocated to six behaviour spheres

VALUE ORIENTATION	ITEM NUMBER				
	1	2	3	4	5
ACTIVITY	Q1	Q10	Q19	Q21	Q25
	RELIGIOUS - PHILOSOPHICAL	ECONOMIC - OCCUPATIONAL	RECREATIONAL	RECREATIONAL	ECONOMIC - OCCUPATIONAL
HUMAN NATURE	Q3	Q8	Q12	Q15	Q23
	ECONOMIC - OCCUPATIONAL	RECREATIONAL	RELIGIOUS - PHILOSOPHICAL	ECONOMIC - OCCUPATIONAL	FAMILIAL
MAN-NATURE	Q5	Q7	Q11	Q17	Q20
	INTELLECTUAL - SCIENTIFIC	INTELLECTUAL - SCIENTIFIC	RECREATIONAL	RELIGIOUS - PHILOSOPHICAL	ECONOMIC - OCCUPATIONAL
RECREATIONAL	Q2	Q9	Q14	Q16	Q24
	POLITICAL	ECONOMIC - OCCUPATIONAL	FAMILIAL	ECONOMIC - OCCUPATIONAL	FAMILIAL
TIME	Q4	Q6	Q13	Q18	Q22
	FAMILIAL	FAMILIAL	RELIGIOUS - PHILOSOPHICAL	FAMILIAL	POLITICAL

within the VOS and the more or less random allocation of inconsistencies across behaviour spheres enhances our confidence in the validity of the VOS as an instrument for tapping general value orientation dimensions.

Cancian is concerned about a possible lack of fit in the "meanings" assigned to alternative responses by Kluckhohn and Strodtbeck on the one hand, and by their respondents, on the other. In the present study, I have not collected data which would allow a direct test of the seemingly adequate face validity of the instrument. To take an example, information is lacking concerning respondents' political orientation. It is therefore not possible to substantiate or refute Cancian's claim that at least one item on the Time orientation is actually tapping radical versus conservative political viewpoints rather than Present versus Future versus Past time orientation. However, I have looked at the relationship between each of the eleven VOS dimensions and a number of demographic and social variables (age, sex, social class, education, marital status, religion, churchgoing, present employment, community sentiment and local bonds). In order to ensure maximum consistency and homogeneity within each dimension (i.e. that a dimension score is made up of component (item) scores which measure the same construct), I have omitted from this analysis the most discrepant item within each value orientation. The face (and construct) validity of each value orientation of the instrument is supported inasmuch as the results conform to predictions which are empirically or theoretically grounded. Table 6.11 reports the outcome of this exercise. Nearly all the findings are in the expected direction. Thus, in the control group, those over 30 years of age tend to be more pronounced in their inclination towards a Mastery over nature position (compared to a

Table 6.11 Relationship between VOS dimensions (four alternative version) and selected demographic variables (for patients and controls separately)

VOS dimension	Patients (N=100)	Controls (N=100)
SUBJECTED TO NATURE - MASTERY OVER NATURE (Man-Nature value orientation)	- Younger (< 30): SUBJECTED > OVER Older (> 30): OVER > SUBJECTED	- Older (> 30) more OVER > SUBJECTED than younger (< 30) - Male more OVER > SUBJECTED than Female - Nonmanual social class more OVER > SUBJECTED than Manual social class - Married more OVER > SUBJECTED than Single
HARMONY WITH NATURE - MASTERY OVER NATURE (Man-Nature value orientation)	- Female more OVER > WITH than Male - Nonmanual social class more OVER > WITH than Manual social class	- Male more OVER > WITH than Female - Nonmanual social class more OVER > WITH than Manual social class
SUBJECTED TO NATURE - HARMONY WITH NATURE (Man-Nature value orientation)	-	- Single more SUBJECTED > WITH than Married
COLLATERAL - INDIVIDUALISTIC (Relational value orientation)	- More local bonds, more COLLATERAL > INDIVIDUALISTIC	- More local bonds, more COLLATERAL > INDIVIDUALISTIC - Manual social class more COLLATERAL > INDIVIDUALISTIC than Nonmanual social class - Less educated more COLLATERAL > INDIVIDUALISTIC than more educated

Table 6.11 continued ...

LINEAL - INDIVIDUALISTIC (Relational value orientation)	- Fewer bonds, MORE INDIVIDUALISTIC > LINEAL - Those professing no religion more INDIVIDUALISTIC > LINEAL than those professing a religion - Nonmanual social class more INDIVIDUALISTIC > LINEAL than Manual social class	-
COLLATERAL - LINEAL (Relational value orientation)	-	-
FUTURE - PAST (Time orientation)	- Nonmanual social class more FUTURE > PAST than Manual social class - More educated more FUTURE > PAST than less educated	- More community sentiment, more FUTURE > PAST
PRESENT - FUTURE (Time orientation)	- Protestants more PRESENT > FUTURE than those professing no religion	- Nonmanual social class more PRESENT > FUTURE than Manual social class
PRESENT - PAST (Time orientation)	- More educated more PRESENT > PAST than less educated	- Nonmanual social class more PRESENT > PAST than Manual social class - More community sentiment, more PRESENT > PAST
PESSIMISTIC - OPTIMISTIC (Human-Nature Orientation)	-	-
DOING - BEING (Activity orientation)	- Churchgoers: DOING > BEING Nonchurchgoers: BEING > DOING	- Less community sentiment: DOING > BEING More community sentiment: BEING > DOING

Subjected to nature position) than the under 30 group; males are more inclined to a Mastery over nature position than females, nonmanual social classes more than manual, and married more than single. In both groups, those with stronger ties to the neighbourhood ("local bonds") tend to be more Collateral than Individualistic on the Relational orientation to a greater extent than those with loose ties to the neighbourhood. Those in the manual social classes and the less educated are also more Collateral than Individualistic compared to the nonmanual social classes and the more educated. In all, there were 27 significant findings in both groups out of a possible total of 220 (11 dimensions, 10 variables in each group separately: 11 x 10 x 2 = 220). Notably, eight of these significant findings related to social class; none of the other variables generated more than three significant findings. In other words, the VOS dimensions correlate more highly with social class than with any of the other more socio-demographic variables. These findings lend support to the face and construct validity of the VOS and its usefulness for describing class-based subcultures.

6.4 Ways of Behaving Instrument (WOBI)

6.4.1 Description

The WOBI is a new instrument specially designed to measure selected aspects of a collectivity's normative system. (Criteria for selection are given below.) The focus upon norms, in addition to the measurement of value orientations, follows from the arguments presented in Chapter 2 that the two elements of culture, though empirically intertwined, are distinctive and separate analytic categories; that the delineation of a subculture or the testing of a

subcultural hypothesis cannot be fruitfully undertaken without reference to norms as well as values; and that the norms "have the pressure of reality upon them" (Blake and Davis, 1964: 461). However, mindful of the difficulties associated with the systematic description of norms (see especially Cancian, 1974), the WOBI does not attempt to portray the whole normative system of the groups interviewed in this study and is not intended as a universally applicable instrument.

The term "norm" is here defined as an evaluation and/or expectation shared by a defined collectivity concerning the behaviour of specific others in specific circumstances. This definition requires some elaboration.

Evaluation

Jackson notes that the idea of evaluation is implicit or explicit in almost all conceptions of the term (Jackson, 1965: 302). "Perhaps the most commonly recognised characteristic of a norm is a shared belief that persons ought or ought not to act in a certain way" (Gibbs, 1965: 589). Thus a norm is an evaluative belief. It is not to be confused with other forms of belief (e.g. existential beliefs) or with behaviour itself: "A norm ... is an idea in the minds of the members of a group, an idea that can be put in the form of a statement specifying what the members or other men should do, ought to do, are expected to do, under given circumstances ... Our norms are our ideas. They are not behaviour itself, but what people think behaviour ought to be." (Homans, 1951: 123, 124).

Mizruchi and Perrucci (1962) draw attention to the evaluative element by focussing upon the nature of action called for by the norm, especially the prescriptive-proscriptive dimension (Williams, 1960; Parsons, 1951): "Norms in which the proscriptive element is most predominant are those which direct participants in the social structure to avoid, abstain, desist and reject all forms of behaviour associated with a particular type of activity ... The prescriptive dimension, on the other hand, directs participants to act in a particular way, spelling out the forms of behaviour to which group members must conform ... Thus the mandate of the predominantly proscriptive norm is 'do not', while the mandate of the predominantly prescriptive norm is 'do this' or 'do that'." (Mizruchi and Perrucci, 1962: 393).

However, if norms can be classified on a prescriptive-proscriptive dimension, two implications (not discussed by Mizruchi and Perrucci) follow.

Firstly, there will be a mid-point on the dimension which may be taken to represent a lack of consensus about the behaviour's normative status, or else an absence of any strong sentiment about the behaviour. However, I think it is of more heuristic value to conceptualise this mid-point as representing a collective evaluation that a behaviour is permitted, rather than prescribed or proscribed. Thus, a third element in the evaluative dimension is available to describe strongly held beliefs that the performance of, or abstention from, a certain activity is entirely at the discretion of the position incumbent to whom the norm is applicable. Secondly, prescription/

proscription becomes a matter of degree, not a fixed quality. Typically, conceptions of norms stress their qualitative nature: a norm exists or it does not. But a norm is not an all or nothing phenomenon. The notion of a prescriptive-proscriptive dimension entails a quantitative conceptualisation of norms; we need to concern ourselves with degrees of normness (Labovitz and Hagedorn, 1973; Jackson, 1966). The importance of looking at the dimension of intensity of feeling associated with a should/should not statement has been stressed by Gibbs (1968b:210), and Labovitz and Hagedorn have specified additional aspects of "normness" which require investigation (Labovitz and Hagedorn, 1973: 299-300). However, only Jackson (1965, 1966) has attempted to develop a standard technique for measuring the intensity of a norm. (A new method suitable for the purposes of the present study has been developed by the author and will be described below.)

Expectation

According to Gibbs, a norm in the generic sense involves not only a collective evaluation of behviour, but also a collective expectation. "Whereas collective evaluations relate to how one ought to behave, collective expectations refer to predictions as to what persons will do; and the two are distinct attributes of norms." (Gibbs, 1965: 589). Gibbs gives examples of a behaviour which is collectively expected to a considerable degree but which is neither proscribed nor prescribed (coffee drinking in the USA); and of a behaviour which is positively evaluated but which is considered to be unlikely or unpredictable (obeying traffic regulations). A convention is an

evaluation of behaviour (i.e. one should/should not behave in a certain way). Gibbs labels a convention "collective" when the evaluation corresponds to the expectation; where people have doubts about others actually conforming to the norm the convention is labelled "problematic". In a note, Gibbs makes the extremely interesting point that "what persons think the degree of conformity is may be far more important as a determinant of their behaviour than is the actual degree of conformity." (Gibbs, 1965: 592, n. 20).

Shared

Most sociologists hold that one crucial characteristic which differentiates norms from values is that norms can never be individualistic and idiosyncratic while values can. "Values can be held by a single individual; norms cannot. Norms must be shared prescriptions and apply to others, by definition." (Morris, 1956b:610). "Norms are learned by individuals in social intercourse with others - that is, in the process of socialization. By definition, then, norms are shared by two or more individuals." (Williams, 1968b:205). Blake and Davis (1964: 456) are willing to apply the label "norm" to "a purely private, or individual, view of what people should do or think", but note that "unless it is shared by others, it has no social significance." One method for deciding upon the existence of a norm is to establish the amount of consensus within a group concerning the way a particular behaviour is evaluated and expected. "Another condition that might signify the absence of a norm is when there is little agreement among the members of a group in regard to a given area of behaviour" (Jackson, 1965:

306). What, however, constitutes "little agreement"? No sociologist would insist upon 100% agreement before granting the label "norm" to a particular evaluative belief. On the contrary, Labovitz and Hagedorn (1973) consider one dimension of "normness" to be the "percentage of the group supporting or not supporting a should statement" (p 299); Williams notes that some norms are characterised by low consensus (Williams, 1968b:206); and Gibbs maintains that "the absence of normative consensus ... does not imply that there are no norms." (Gibbs, 1968b:210). However, as Gibbs (1968b:210) points out, the absence of complete consensus requires some statistical criterion; and whatever number is chosen as the minimum percentage of a group which must subscribe to a particular evaluative belief before it can be labelled a norm, that number is necessarily arbitrary.

Defined Collectively

Industrialised societies are characterised by a high degree of social differentiation, leading to a proliferation of sub-cultures and social groupings. "In fact, so diverse are the subcultural norms of most large societies that there are probably only a few norms which are accepted as binding on all persons." (Clinard, 1961: 11). With the exception of these strongly held and socially obligatory institutional norms (Williams, 1968b:206), there is a considerable variation in both quantitative and qualitative aspects of norms, especially within relatively hetereogeneous societies such as Great Britain or the USA. "The assumption that for each society there is one norm ... regarding a given aspect of behaviour is in most instances untrue." (Blake and Davis, 1964: 463). It is therefore

necessary to state clearly which group/category/collectivity is being studied. Thus Cancian (1974) focuses upon the "local normative system", while Clinard (1961) refers to "neighbourhood norms", i.e. district behavioural norms in neighbourhoods.

Behaviour

Norms may arise in relation to any aspect of human activity and experience that is regarded as important. Thus there are norms for perceiving, thinking, feeling, judging, evaluating and behaving (Williams, 1968b:205). The WOBI focuses solely upon selected norms relating to behaviour, commonly called social norms. "Social relationship and behaviour are regulated through social norms - standardised ways of acting or expectations governing limits of variation in behaviour" (Clinard, 1961: 9; emphasis in original). For Williams (1968b:205) social norms designate rules of moral conduct which guide direct social interaction. Wolfgang and Ferracuti (1967: 101) and Sellin (1938: 28) refer to conduct norms, i.e. rules attached to the way one behaves in certain circumstances.

Specific Others

Morris defines norms as "generally accepted, sanctioned prescriptions for, or prohibitions against, others' behaviour, belief or feeling - i.e. what others ought to do, behave, feel." (Morris, 1956b:610). In his typology of norms Morris emphasises the need to define the extent of application of a norm to objects, i.e. to which groups or categories the norm applies. Homans' definition (see above) also refers to "what

the members [of a group] or other men should do, [etc.]." (Homans, 1951: 123; see also Homans, 1961: 46).

Specific Circumstances

Nearly all definitions of norms note that the requirement to behave in certain ways relate to specific circumstances. Thus, Gibbs: [M]ost prescriptions or proscriptions of conduct are relative to ... situations ..." (Gibbs, 1968b: 210). Williams (1960: 24) notes that norms "specify what should and should not be done ... in various kinds of situations ..." (see also Wolfgang and Ferracuti, 1967; Blake and Davis, 1964; Dutta, 1969; Bidwell, 1966; Kitsuse, 1975; Bierstedt, 1963; and Homans, 1961).

The definition of norm used in this study does not refer to sanctions or to conformity. For some sociologists (e.g. Cancian, 1974; Morris, 1956b; Homans, 1951; Kitsuse, 1975; Blake and Davis, 1964) sanction is a definitional attribute of a norm. Indeed, according to Homans, where departure from a rule does not invoke sanctions, that rule is not a norm at all, but an ideal (Homans, 1951: 123-4). (Kitsuse (1975: 277) also makes the same point.) However, Clinard (1961), Williams (1968b), Gibbs (1965, 1968b) and Wilson (1969), among others, do not include sanctions in their definition of norm; they are treated as contingent attributes. There is more agreement among sociologists with Gibbs' view that the degree of conformity to norms is not a fixed attribute (Gibbs, 1965: 588; see also Bierstedt, 1963; Williams, 1968b; Blake and Davis, 1964;

Morris, 1956b; and Cavan, 1961). However, there are clearly problems involved in applying the label norm to a belief or expectation which commands little conformity among those to whom the norm applies.

How do we go about measuring conduct norms? Systematic attention to the problems of conducting research on normative phenomena is rare (Gibbs, 1968b). New techniques have tended to be most applicable to the analysis of small groups (e.g. Jackson, 1965, 1966), or organisations (e.g. Kahn et al., 1964) or small, relatively homogeneous communities (Cancian, 1971, 1974, 1976). In addition, Cancian's frame-sorting method, while methodologically and conceptually sophisticated, was both costly and time-consuming; these problems would be exacerbated when attempted to apply the technique to larger, more differentiated societies.

Since norms cannot be directly observed they must therefore be inferred from verbal or nonverbal acts. Labovitz and Hagedorn (1973) refer to four techniques for measuring norms: by questioning people, by inference from behaviour, by measuring the implications ("postulated effects") of hypothetical norms, and by examining written documents. Direct questioning and inferring from behaviour are the most commonly used methods, though each has its advantages and drawbacks. Observing a behaviour pattern and imputing a norm from it may be an invalid procedure because the observation itself may be incorrect or misrepresent the real situation (Labovitz and Hagedorn, 1973: 292). Secondly, the behaviour may not reflect a social norm at all, but other factors (e.g. economic) (Labovitz and Hagedorn, 1973). "[S]ociologists may perceive norms where members see nothing at all." (Kitsuse, 1975: 278). Jackson (1965) and Williams (1968b) both point to the need to distinguish parallel responses to conditions from

behaviour which is normatively regulated. Thirdly, the danger of tautology or circular reasoning arises when norms are derived from a behavioural regularity and then used to explain the behaviour in question (Labovitz and Hagedorn, 1973; Cancian, 1974; Blake and Davis, 1964). Finally, a sociologist using this method may rely overmuch on his own implicit and tacitly held understanding of social norms. His characterisation of norms, however, may differ radically from those of members (Kitsuse, 1975), especially when those under investigation are located in a distant segment of the social structure.

The technique of questioning people as a means of constructing a picture of the local normative system, though widely used, is subject to criticism, both at the general level (i.e. as a valid strategy for describing norms) and in relation to the specific methods and circumstances of its use (e.g. as a questionnaire in a survey). The most radical attack on the validity of this technique is made by Dahrendorf (1968), who criticises Gross' suggestion (Gross et al., 1958) that, as a way of discovering how reference groups influence the positions and roles they define, we ask the members of a given position's reference groups what expectations they associate with the position's incumbent. "By attributing the force of social norms to the uncertain basis of majority opinions, [Gross] makes the fact of society subject to the arbitrariness of questionnaire responses ... Role expectations are not modes of behaviour about whose desirability there is more or less impressive consensus; they are modes of behaviour that are binding for the individual and whose binding character is institutionalised, i.e. valid independent of his own or anyone else's opinion." (Dahrendorf, 1968: 48). Role expectations are defined by "society", which although constituting a reality sui

generis, can be conceptualised as the reference groups which make up a particular person's relational field. "Generally speaking, it is possible to identify in any human group those rules and sanctions by which it influences the behaviour of its members ... These rules and sanctions, which can in principle be separated from the opinions of both members and non-members, are the origin of role expectations and their binding character." (Dahrendorf, 1968: 49). Dahrendorf maintains (p 50) that it is not the validity but the legitimacy of norms that is challenged by the opinions of those affected. There is a need to distinguish between the fixed norms of reference groups, on the one hand, and the opinions of members of reference groups about these norms, on the other. In the case of mandatory or "must" expectations, i.e. those supported by the force of law and the sanctions of law courts, society as a whole constitutes a reference group. "Society as a whole here means all members of a society to the extent that they are represented by legislative and judiciary institutions." (Dahrendorf, 1968: 51).

Although Cancian does not directly comment upon Dahrendorf's "Homo Sociologicus", her views are clearly and diametrically opposed to the latter's rejection of the inductive method. Insisting upon the need for a phenomenological/subjective approach to the measurement of norms, she develops a vigorous methodology that begins with the actor's point of view and aims to build up a complete picture of the local normative system (Cancian, 1974: Chapter 2). According to Cancian, previous studies have failed to construct adequate measures of norms, either because the measures were unreliable (especially true of anthropological investigations) or because they were not based upon a valid model of the actor's belief system (a problem often encountered in surveys by sociologists and psychologists).

"[A] valid method must attempt to represent the cognitive structure of the population being studied and must avoid confounding their categories and beliefs with those of the investigator." (Cancian, 1974: 12). Where Cancian and Dahrendorf are in agreement is their belief that the description of the local normative system using the methodology of the survey and the questionnaire is likely to be incomplete and/or invalid. More specific criticisms of the measurement of norms by direct questioning have been made by a number of authors: the respondent may tell the investigator what he thinks the investigator wants to hear, rather than his own views (Labovitz and Hagedorn, 1973); the respondent's statement may be the expression of an ideal, rather than of a norm (Kitsuse, 1975; Homans, 1951); the respondent may lie about his beliefs (Labovitz and Hagedorn, 1973); the respondent may have no real opinion but be forced to give one by the structure of the questionnaire; the questions used to elicit normative beliefs may not have an invariant meaning to different respondents (Labovitz and Hagedorn, 1973). Reference has already been made to an additional problem associated with this method of constructing the normative system of a group. How much consensus is required between group members before an evaluation or expectation can be counted as a norm?

The method chosen in this study to measure and describe group norms is the self-report questionnaire. Dahrendorf's rejection of the direct questioning of individuals is not considered convincing. While he makes a useful analytic distinction between the validity and the legitimacy of norms, he is not willing to pay any attention to members' opinions when assessing the existence of a norm. However, how we are to "identify ... reference groups and then find out what norms obtain in these groups" is nowhere made clear.

Dahrendorf equates "must-expectations" (i.e. institutional norms) with legally enforced and sanctioned prescriptions and proscriptions, without taking into account the fact that the legislative and judiciary, as well as other organs of the state, may represent a mobilisation of bias: their activities may not be in the interests of all members, or command widespread support, or reflect the wishes of the majority. The coercive law of a dictatorship and the collective law of a parliamentary democracy are similar in that both are likely to be enforced by sanctions, including the use of force. However, the coercive law commands neither popular support nor a shared expectation of conformity, while the collective law corresponds to shared evaluations and expectations. (For these distinctions, see the typology of norms in Gibbs (1965).) According to most definitions, the coercive law cannot be considered a norm at all; its validity (as well as its legitimacy) is certainly affected by the opinions of those concerned. On the identification of other types of norms, Dahrendorf is even less helpful. For permissive norms ("Can - expectations") we are urged to consult students or sociologists, but not members of the relevant reference groups! For the rest, we must presumably infer from behaviour. The difficulties with this method have already been discussed.

Cancian's rejection of typical sociological approaches to the measurement of norms was not based on an indifference to what people think, but on what she saw as their inability to capture such subjective data with an adequate degree of reliability and validity. I will present data below to support my claim that the self-report questionnaire can still be used to describe normative beliefs in a reliable and valid manner. Whether it is also adequate to describe the total local normative system is a separate issue. It should be

remembered that I was only interested in gathering information on certain conduct norms which were presumed to be associated with the prevalence and normative status of parasuicidal behaviour. The self-report questionnaire can also serve to determine whether evaluative beliefs should be considered as norms at all.

The Ways of Behaving Instrument (WOBI), presented in full in Appendix 6.5, consists of two separate sections. The first presents a list of nineteen different ways of behaving which the respondent is asked to evaluate on an analogue scale. In order to minimise the risk of defensive, distorted and/or idealised responses the respondent rates the behaviour of an "average" person rather than his or her <u>own</u> behaviour. The focus upon typical role incumbents ("young married couple", "married woman with young children", "man", "parents", etc.) and the local neighbourhood ("... in my area ...") emphasises the notion of neighbourhood norms and directs attention away from idiosyncratic, personal standards of evaluation which the individual applies only to him/herself. The 100 mm analogue line is labelled at both extremes ("absolutely should" and "absolutely should not") and also at the mid-point ("may or may not"). Respondents were carefully instructed in the use of the scale, with particular attention given to the opportunity for registering degrees of "should-ness" and "should not-ness" (i.e. intensity of prescriptive or proscriptive evaluations) and the meaning of the mid-point on the scale. (See the Instructions relating to this section of the WOBI, Appendix 6.4.) The second section presents the same list of behaviours in the same order as in Section 1. On this occasion, however, respondents are asked to make a personal judgment concerning the likelihood or probability of average people in the area actually behaving in a particular way. For each item the respondent is

required to put a mark at the appropriate point on a 100 mm analogue line which is marked "very likely" at one extreme and "very unlikely" at the other. Formal instructions given to the respondent on the use of this section of the scale are also found in Appendix 6.4.

It has already been stated that the WOBI is not conceived as a device to provide a comprehensive description of "the local normative system". The instrument was constructed in order to assess the normative status of selected modes of behaviour which have been linked (theoretically and/or empirically) either with parasuicide or with the subculture of the social class where parasuicidal behaviour is most prevalent (i.e. the working class(es), especially semi-skilled and unskilled manual labour). In summary, the major criteria for choosing items for the instrument were as follows:

(1) they were to refer to overt behaviour, not feelings, thoughts, etc.; and

(2) the behaviour was to have consequences for the individual's identity or standing in the community; it was therefore not to be trivial or idiosyncratic or esoteric, but likely to evoke strong, collective evaluations and/or expectations; and

(3) the behaviour was likely to evoke differential responses according to the social class (working class vs not working class) or parasuicide (parasuicide vs not) status of the collectivity whose normative system was being examined.

From a pool of over forty items, culled from the literature on parasuicide and class subcultures, twenty-four were originally used in the first version of the WOBI. The third and final version uses

nineteen items.

The introductory Instructions were read out informally by the interviewer, then the WOBI was normally completed by the respondent. In eight cases where the respondent was unwilling/unable to complete the instrument, I read out each item and allocated the response to one of five categories into which each scale was collapsed. In the case of the evaluation scales (Section 1) these categories were: should - strongly held opinion; should - moderately held; may or may not; should not - moderately held; should not - strongly held. A mark was placed at a fixed point on the line according to the response category (should - strong at 7 mm, should - moderate at 33 mm, may/may not at 50 mm, should not - moderate at 67 mm and should not - strong at 93 mm). The response categories for the expectation scales (Section 2) and their fixed "score" (i.e. distance along analogue line) were: very likely (7 mm), somewhat likely (33 mm), as likely as unlikely (50 mm), somewhat unlikely (67 mm), very unlikely (93 mm).

6.4.2 Pre-test procedures

The WOBI used in the study was the third version of the instrument to be constructed. The first version consisted of five sections: personal expectation of frequency of behaviour of "people like yourself who live in your area"; personal evaluation of behaviour of others; the respondent's perception of the evaluation of behaviour by "average people like yourself living in the area; personal reaction to "anyone" behaving in a particular way; respondent's perception of the reaction of "average people like yourself" living in the area. All sections contained the same list

of 24 items presented in the same order. Each item had to be rated on one of a number of discrete categories, not on a continuous line. This version of the WOBI was tested on a non-random sample of 15 middle-class women in south Edinburgh during November - December 1978. A number of criticisms of the instrument were made: it was felt to be too long and cumbersome; respondents found it difficult to put themselves in the place of "average people"; the categories used to measure evaluations and reactions were neither exhaustive nor self-explanatory; and some of the items were felt to be "out of place", not "the same kind of thing" as other items. In retrospect, I also became aware of two further deficiencies in the instrument. Firstly, the extent of application of norms to objects was not consistent throughout; expectations were related to "people like yourself who live in your area", whereas evaluations and reactions were related to <u>any</u> position incumbent without further specification. Since I was interested in exploring the local normative system, all behaviours should have been contextualised by reference to both social position and social location. Secondly, in order to establish the existence of norms of common consent (i.e. norms on which there is in fact consensus), I would have to focus upon the beliefs of respondents about norms thought to be current in their location. The focus upon idiosyncratic standards and evaluations (personal norms) was therefore misplaced and redundant (as well as being confusing for the respondent).

The second version of the WOBI was tested on another sample of convenience, seventeen patients admitted to the RPTC during January to March 1979. This version consisted of three sections only: personal expectation about different behaviours (each rated on a 100 mm analogue line, labelled "not at all common" at one extreme and

"extremely common" at the other); personal reaction to different behaviours (each rated on an analogue line, labelled "encourage" and "prevent" at the two extreme and "do nothing" at the mid point); and personal evaluation of different behaviours (each rated on one of four categories - "should", "should not", "may", "not sure" - and also according to whether or not "there are any circumstance which might make you qualify your previous answer"). Each section contained an identical list of 19 items of which 16 were based on items in the first version and three were entirely new. Eight items on the original version were dropped: one was redundant (similar to another item), three appeared to be non-normative (i.e. there was no collective evaluation or expectation of their occurrence), two were not equivalent to other items (i.e. did not appear to tap the same sub-cultural themes), and two generated on excessive number of "not sure" responses.

The response to the new version was far more encouraging than the response to the earlier version. The principle of rating the analogue scales was easily understood and there was evidence that the whole of the scale - not merely the extremes - was being used. None of the items now appeared to be redundant or unclear. However, there was an extremely high correlation for all items between Reaction and Evaluation scales, and the Evaluation section was clearly confusing and over-elaborate. It was therefore decided to omit the Reaction section altogether in the third and final version of the WOBI and re-cast the items in the Evaluation section in the form of more easily understood analogue scales. The items were not altered substantially for the final version, but slight changes in wording were made to seven items (Q1, Q2, Q5, Q9, Q12, Q14 and Q19 in the present version).

6.4.3 Reliability

Reliability of the WOBI was assessed by examining the test-retest stability of each of its constituent scales. Thirty-five respondents from the main study were re-interviewed approximately eleven weeks after the first interview (see above). The Pearson correlations between interviews for individual Evaluation scales ranged from .162 to .721 with a mean value of .445. Only four items were not significantly correlated ($p>.05$, 2 tail): items 5, 9, 11 and 14. There were only two items with significantly different mean scores at the second interview compared to the first: Item 3 ($T = -2.19$, 33 d.f., $p = .036$) and Item 8 ($T = 2.39$, 34 d.f., $p = .023$). Neither of the items with non-significant correlations had significantly different mean scores between interviews. Correlations for individual Expectation scales ranged from .029 to .854, with a mean value of .519. Three items were not significantly correlated: items 5, 11 and 15. There was only one item with a significantly different mean score at the two interviews: Item 7 ($T = 2.11$, 31 d.f., $p = .043$). Again, the items with non-significant correlations did not have significantly different mean scores between interviews.

Changes between interviews in WOBI item scores were also correlated with changes in ABS scores, in order to rule out the possibility that any instability in the instrument might reflect changes in mood state. There was no correlation (Pearson r, $p<.05$, 2 tail) between change in the ABS score and change in Evaluation item scores for the re-interviewed group. Turning to the Expectation

section, we find one significant positive correlation (between change in Item 3 and change in ABS score for the whole group ($r = .39$, $p = .024$) and one significant negative correlation (between change in Item 6 and change in ABS score for the whole group ($r = -.44$, $p = .014$)). The relationship between Item score and ABS score at each interview was also examined. Four Evaluation items were significantly and positively correlated with ABS score at first interview in the whole group: Item 3 ($r = .36$, $p = .038$), Item 7 ($r = .50$, $p = .002$), Item 11 ($r = .39$, $p = .022$) and Item 13($r = .34$, $p = .05$). At the second interview there were no significant correlations between any Evaluation item and ABS score. In the Expectation section, there was no significant correlation at the first interview between Item scores and ABS score. At the second interview significant correlations were found between ABS score and items 2 ($r = .35$, $p = .046$), 3 ($r = .36$, $p = .036$) and 17 ($r = .37$, $p = .030$). This analysis demonstrates that while the individual's mood state does have some influence over scoring on certain Evaluation items at the first interview, it has no or little effect over scoring on Expectation items. Furthermore, it was also shown that changes in item scores and changes in ABS score were largely unrelated, the number of significant findings being no greater than could be expected by chance alone. We can therefore conclude that only a small part (at most) of the instability reported above can be attributed to changes in the individual's mood state.

6.4.4 Validity

The WOBI is intended as a device for establishing the existence of group norms, or norms of common consent, on the basis of normative beliefs and expectations expressed by individuals on a self-

administered questionnaire. The legitimacy of this approach has been defended against Dahrendorf's view that the delineation of norms cannot be achieved by direct questioning of individuals. However, a wholly inductive methodology (such as Cancian advocated) has been rejected as unsuitable in the context of the present study on the grounds that it is neither practicable (due to scarcity of resources) nor necessary, since no attempt at capturing the total local normative system was considered. The framework of the analogue scales, the labels attached to anchor points on the scales, and the behaviours listed all constituted understandable and relevant cognitive elements to respondents (see further discussion below). Respondents also clearly grasped the distinction between evaluations and expectations. As we will see, this distinction was most pertinent in the HRA and was made spontaneously by many HRA residents when completing section 1 (Evaluation) of the WOBI. It is therefore most unlikely that responses to scales in either section were an invalid mixture of evaluations and expectations.

The WOBI allows a comparison of the relative strength (intensity) of opinions about different behaviours since its conceptualisation of a norm is quantitative, not qualitative. Though the instrument itself cannot be directly used to decide how much consensus of opinion about an item of behaviour is needed before the opinion can be labelled a norm, the distribution of responses on the instrument can constitute a useful indication.

The WOBI, then, has reasonable face validity as a method for capturing the individual's evaluations and expectations of specific items of conduct. That is to say, there is a clear and logical link between the form and content of the instrument and the conceptual-

isation of norms discussed above. However, in practice the results obtained using the WOBI depend ultimately upon the extent to which the individual's responses are a "true" indication of his/her beliefs. While it is never possible to eliminate the risk of deliberate lying and distortion by the respondent, measures were taken in this study to reduce this risk to a minimum. Following the advice of Pomeroy (1963), substantial efforts were made to convince respondents that the research was important and useful to others; that the information given would be kept in confidence; and that the beliefs expressed would not be judged or morally evaluated by the interviewer. Freedom to express what they "really" believed was also encouraged by the use of the self-report method rather than direct questioning (on this point see Sudman and Bradburn, 1974) and by asking respondents to disclose their personal evaluations and expectations in relation to others' behaviour rather than in relation to their own.

While introducing the WOBI to the respondent it was clearly implied that any response on the analogue scales was legitimate. This led to a singular difficulty, namely, that some respondents could not easily conceive a meaning for certain parts of certain scales, e.g. the "should" part of the scale measuring the evaluation of suicide. On occasion I was asked how anyone could think that a person should commit suicide. Although it would be possible to imagine situations where the proposition "this man should commit suicide" might be understandable and receive support (e.g. in order to avoid definite enslavement or torture), it is probably not considered to have any meaning unless contextual details are provided. It therefore differs from such propositions as "this man should help around the house", since both support for and opposition

to this evaluation are conceivable and meaningful. However, rather than make an a priori decision about which behaviours would be evaluated exclusively as prescriptions or proscriptions, and in order to encourage highly deviant responses which might have been felt but not otherwise expressed, the scales for each item were the same throughout. This strategy was vindicated by finding a number of unexpected (deviant) responses among the patients and even some among controls (more in the HRA than in the LRA). Finally, to encourage valid responses, the Not Sure category was explicitly pointed out to each respondent and, while its use was not urged, it was made clear that this was available in certain specific circumstances (see Appendix 6.4). In this way it was hoped that respondents with luke-warm opinions about one of the Evaluation scales would be encouraged to put a mark on the analogue line in the appropriate place (towards the centre), while those with no opinions would make use of the 'Not Sure' box.

Despite all these safeguards, it is still possible that the information given is not adequate as a basis for establishing valid measures of group norms. While there are no foolproof means for detecting the presence or extent of distortion, misunderstanding, yea-saying, etc., certain evidence available from the data gathered in the main study suggests that the safeguards have been fairly successful in achieving their purpose.

Rutter and Brown put forward the view that the validity of 'sub-jective' material

"may be assessed indirectly by re-test reliability, that is whether the person expresses the same attitudes when he is re-

> examined after an interval of time .... [I]f measures are valid, it may be expected that somewhat similar emotions should be manifest in similar situations on different occasions, so that repeated observations offer some test of validity if the observations are carried out independently by different observers." (Rutter and Brown, 1966: 40).

In this study the self-report method was used, ruling out the element of "independence" between observations (or, more generally, approaches) which has been held to be fundamental to the major types of validity (Cronbach and Meehl, 1955: 281-282; Cureton, 1968: 105-106; Campbell and Fiske, 1959). On the other hand, the context in which the interview takes place is likely to differ on the two occasions, especially for the patients, due to the impact of life events and experiences during the intervening period. Inasmuch as the test-retest reliability coefficient measures the degree to which attitudes are consistently reported in different situations, it can be legitimately treated as a proxy or surrogate indicator of validity. While complete agreement between interviews would be exceptional because of genuine changes in opinions, different use of the scales, etc., a low association between the two sets of ratings would cast serious doubts upon the usefulness of the measures (Brown and Rutter, 1966: 251). The evidence presented in the previous section suggests that the WOBI exhibits an acceptable, if modest, level of test-retest stability; and that little change in rating on the instrument can be attributed to change in mood state. Our confidence in the validity of the WOBI is thereby enhanced. (It should be stressed that this is not, of course, the only measure of validity used in the present study, nor even the most important.)

In the previous section it was reported that for the whole followed-up sample (N = 35) the correlation for Evaluation items ranged from .162 to .721 with a mean r of .445; four values were not significant. For Expectation items the range was from .Ø29 to .854, with a mean r of .519, and three non-significant values. Change in mood-state was largely ruled out as an explanation for the test-retest instability that was revealed. On the whole, the instrument exhibits an acceptable, if modest, level of test-retest stability and, hence, of validity.

Use of the scales is reported in Tables 6.12 and 6.13. There was a significantly higher mean number of Evaluation items rated 'Not Sure' among patients than among controls in the LRA ($p<.Ø5$); while in the HRA a significantly higher mean number of Expectation items was rated 'Not Sure' by patients than by controls ($p<.Ø2$). There were no significant differences between control or patient groups. The number of 'Not Sure' ratings allocated to each individual item was analysed. Patients and controls tended to agree ($r_s=.8Ø$, $p<.ØØ1$) on the rank ordering of items according to the number of 'Not Sure' ratings given; and there was also significant agreement between the two sections ($r_s=.71$, $p<.Ø1$). For each section and each group (patient and control) the items which generated the most 'Don't Knows' were items 6 and 16, i.e. those relating to suicidal behaviour. The overall pattern of 'Not Sure' responses over items was significantly different from what would be expected by chance ($\chi^2 = 88.61$, 18 d.f., $p<.ØØ1$). Since patients in each area had been resident at their current address for a significantly shorter period than their matched controls (see Table 8.1), an analysis was undertaken to test whether there was an inverse relationship between the number of items scored 'Don't Know' and length of time at current

Table 6.12 W.O.B.I. - Use of 'Not Sure' category

(a) Evaluation

Number of Evaluation items scored 'Not Sure'	LRA		HRA	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
0	33	40	35	39
1	7	8	9	5
2	3	2	2	3
⩾3	7	0	4	3
TOTALS	50	50	50	50
Mean n of items scored 'Not Sure'	1.32	0.24	0.56	0.54
(S.D.)	(3.27)	(0.52)	(1.11)	(1.40)

(b) Expectation

Number of Expectation items scored 'Not Sure'				
0	26	32	21	34
1	12	9	7	5
2	3	3	8	6
⩾3	9	6	14	5
TOTALS	50	50	50	50
Mean n of items scored 'Not Sure'	1.58	0.82	1.84	0.88
(S.D.)	(3.26)	(1.51)	(2.43)	(1.69)

address. Among LRA controls and HRA patients there was no relationship whatsoever (Evaluation and Expectation items considered separately). Among LRA patients there was a positive relationship between length of stay and number of 'Don't Knows' (Evaluation) ($r = .40$, $p = .004$, 2 tail) and between length of stay and number of 'Don't Knows' (Expectation) ($r = .38$, $p = .006$, 2 tail). Among HRA controls length of stay and number of Evaluation 'Don't Know' items was correlated positively ($r = .31$, $p = .028$, 2 tail). These surprise findings certainly rule out the possibility that patients score more 'Don't Knows' because of a shorter stay in the area.* In view of the failure to find differences in the use of the 'Don't Know' category between patient groups and between control groups; the greater prevalence across all groups of 'Don't Know' responses in the Expectation section than in the Evaluation section; and the relatively small mean number of items rated 'Don't Know' (highest = 1.32 in the Evaluation section and 1.84 in the Expectation section), it is concluded that "Don't know" responses do not systematically bias the substantive findings of the study.

The data given in Table 6.13 concerning the use of extreme scores also support this contention. There are no significant differences in the mean number of items (Evaluation or Expectation) given extreme scores (0-5 or 96-100 on the 100 mm analogue line) between control groups, between patient groups or within either area. Thus, no tendency is discernible of "dichotomous thinking" (i.e. the excessive use of extreme values on the scales) among patients, a tendency which might have been expected (see, e.g. Neuringer, 1961, 1976) and which might otherwise have threatened the validity of the instrument.

* The implications of these findings are less obvious. Four possibilities suggest themselves: (1) the instrument is not valid; (2) the assumption that people acquire knowledge of norms via everyday experience is incorrect; (3) the greater the exposure to the normative system, the greater the degree of confusion about its content; (4) the assumption that area norms exist is mistaken. On the basis of evidence presented in this thesis, (1) and (4) are rejected.

Table 6.13 W.O.B.I. - Use of Extreme Scores

(a) Evaluation

Number of Evaluation items scored 0-5 or 96-100	LRA		HRA	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
0	9	11	10	9
1-3	14	11	16	13
4-6	10	9	8	5
7-9	12	7	2	8
10+	5	12	14	15
TOTALS	50	50	50	50
Mean score	4.62	5.20	4.96	5.80
(S.D.)	(3.97)	(4.50)	(4.79)	(4.72)

(b) Expectation

Number of Expectation items scored 0-5 or 96-100				
0	18	16	21	19
1-3	19	11	12	12
4-6	7	11	3	5
7-9	1	6	7	3
10+	5	6	7	11
TOTALS	50	50	50	50
Mean score	2.80	3.84	3.82	3.92
(S.D.)	(3.72)	(4.27)	(5.19)	(4.93)

Analysis of ratings also rules out the likelihood of a widespread fixed response set among respondents. Table 6.14 presents the relevant data. From this Table it can be seen that the maximum mean (and median) number of Evaluation items given the same score (within a 10 mm band) ranged between six and eight, with little difference between groups. No more than seven respondents in any group gave the same rating to half or more of the items. In the Expectation Section, there is again little difference between groups in the mean, or median number of items given the same rating, or in the range of ratings, but there was a tendency for more response set in the HRA. This became more apparent when we examine the N of respondents giving the same score to half or more of the items: three LRA patients and five LRA controls, compared to eleven HRA patients and eight HRA controls. However, visual inspection of these nineteen HRA cases shows that in only two cases (both parasuicides with scores of fifteen and eighteen) did a true response set appear evident.

6.5 Case Vignette Instrument

6.5.1 Description

Although the normative status of parasuicidal (and suicidal) behaviour in general was assessed by the WOBI, it was felt that a more thorough exploration was required of the perception, definition and interpretation of specific behaviours which fall under the social psychiatric rubric of "parasuicide". From a sociological viewpoint the concept "parasuicide" is clearly problematic. In

Table 6.14 W.O.B.I. - Response Set

Section	LRA		HRA	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
EVALUATION				
Maximum mean n of items given the same score*	6.5	7.4	7.4	7.4
Median	6	7	7	8
Range	3-11	4-14	4-16	4-13
n of respondents giving same score* to ⩾ 10 items	2	7	7	6
EXPECTATION				
Maximum mean n of items given the same score*	6.5	6.3	7.5	7.2
Median	6	6	7	6
Range	3-17	3-12	3-18	3-15
n of respondents giving same score* to ⩾ 10 items	3	5	11	8

* 100 mm analogue line was divided into nine equal sections. "Same score" signifies ratings on the line falling within the same 11 mm section.

the first place, it is a (medical) experts' term: not only is it unknown to, or unused by, members, but it may also encompass a class of different behaviours which is not seen to be homogeneous or natural to members themselves. Thus, members faced with two situations which are labelled parasuicide by experts (e.g. young girl takes six aspirin after row with boyfriend; middle-aged man found with head in noose after weeks of severe depression) will not use the word "parasuicide" to refer to either. Moreover, they might consider that the two situations are more dissimilar than similar: there might be no one common link between them which permits their classification in the same conceptual category. Secondly, it is doubtful whether a particular act is interpreted in terms of the elements which constitute the experts' definition of parasuicide. It is not a fruitful procedure to ask members - as Simmons (1965) did - to state whether a certain form of behaviour (in this case "parasuicide" or "attempted suicide" or "suicide gesture" or whatever) is deviant. As McHugh (1970) points out, a deviant act is not identified or located in terms of its "effects" or "causes" but in its production. And once we label a behaviour ("parasuicide", "delinquency", "terrorism", etc.) we are already supplying a range of connotations and stereotypes that go with it. The key questions concern how members define and interpret the behaviour of alter as it happens, and how they come to perceive an action as rule-breaking or not. Asking people if "attempted suicide" etc. is "deviant" is unhelpful, because we cannot know whether different people/groups have the same picture in their heads of "attempted suicide" or "deviance", and we do not know whether this generalised stereotypical attitude will have any bearing on their behaviour when someone "does" "attempted suicide". Douglas (1967: 184) makes the further point that two people may agree explicitly on what "suicide" means yet disagree completely about

whether or not a specific case should be categorised as a "suicide".

The exploration of these issues is vital in the context of a subcultural explanation of parasuicide. As we have seen in Chapter 4, it is hypothesised that there will be differences in the cognitive, affective and moral evaluations of parasuicide:

(a) The perception of parasuicide is expected to differ in the two area-types. In the HRA there is likely to be more discrimination between different "types" of parasuicide, and a lesser tendency to label such behaviours death-intended or death-orientated, than in the LRA.

(b) The attitude towards parasuicide is expected to differ in the two area-types. In the HRA there are likely to be more favourable and understanding attitudes to all forms of parasuicide, especially the more medically trivial "suicidal gesture" - type parasuicide.

(c) The moral evaluation of parasuicide is expected to differ in the two area-types, with less imputation of immorality in the HRA.

The instrument used to study the normative status of parasuicide is presented in Appendix 6.7. Four parasuicide "cases" are presented and the respondent is asked to indicate his/her agreement or disagreement with nine statements, separately for each case. A Likert-type format is used, each category being given a numerical score as follows: strongly agree - 1; agree - 2; not sure - 3; disagree - 4; strongly disagree - 5. Except in minor details, the cases are those used in a series of studies on motives for parasuicide and attitudes towards suicide carried out by Bancroft and colleagues in Oxford (Hawton et al., 1978, 1981; Ramon et al., 1975. See also, Ramon, 1980; Ramon and Breyter, 1978). The cases

are described in Ramon et al., 1975: 262-3. (Case 2 in the present study corresponds to Ramon et al's Case 4; and the present Case 4 to their Case 2.) The descriptions, based on actual cases, were chosen to provide typical or "normal" (Sudnow, 1965) examples of parasuicidal behaviour. In Case 1 a row in a marriage with poor communication precedes the overdose. Case 2 represents a depressive history in a middle-aged man with various situational factors to account for his depression. Case 3 shows an alcoholic with a steady social decline and repeated overdoses. In Case 4 an adolescent girl with an insecure home background is upset by the threat of a break with her boyfriend. The method of parasuicide in cases 1, 3 and 4 is by overdose of tablets and by carbon monoxide (car exhaust) fumes in Case 2. Cases 1 and 4 were chosen as typical of those with low suicidal risk, and Cases 2 and 3 of those with high suicidal risk.

The respondent was asked to read through the first case and then respond to the statements before going on to repeat the process with the other three cases in turn. Each case was to be treated separately and judged on its own merits. (See Appendix 6.6 for the instructions given to the respondent for completion of this instrument.)

Each statement was chosen to elicit information about respondents' perceptions and definitions of, and attitudes and reactions towards, behaviour which is officially classified as "parasuicide". Statements 1 and 6 explore the idea of parasuicide as an act which is comprehensible and intelligible, appropriate to the circumstances of the person (S1) or to the specific problems facing him/her (S6). The idea that parasuicide is a sanctionable act is presented in S2. S3 enquires whether the act is pragmatic, i.e. "right under the circumstance", while the typification of the para-

suicide as a victim, not responsible for his/her actions, is the focus of S4. S5 and S9 ask whether the act is perceived to be death-related. S5 explores whether the parasuicide wishes to die while S9 asks whether she/he is attempting to die. These aspects were explored separately, since a person may try to risk his/her life without a clear intention to die, or want to die without trying very hard. The morality of the act is the subject of S7, and S8 introduces the idea of parasuicide as a legitimate problem-solving activity.

All respondents were expected to fill in their response to the four imaginary vignettes. For the eight respondents who were unwilling/unable to do so, I read out each vignette and the nine statements in turn, with as many repetitions as were necessary.

6.5.2 Pre-test Procedures

The original version of the Case Vignettes was tested on a non-random sample of twelve patients admitted to the RPTC during January - - March 1979. The original instrument consisted of the same four cases presented in the same order, but with eleven statements attached to each. Statements 1, 2, 3, 5, 7 and 9 in the final version appear unchanged, while slight amendments were made to the wording of items 6 and 8. Item 4 on the final version is an amalgamation of two items on the original instrument. ("S could not help him/herself when she/he took the pills" and "S did not really want to do what she/he did. It was something that just happened to him/her".) One item on the original schedule ("Given her situation, it was the only thing Mary could do") was dropped altogether in the final version.

The original version was well received. Respondents stated that they found the cases interesting and believable; few 'Not Sure' responses were recorded. Analysis of intercorrelations between each pair of vignettes for each respondent showed an average inter-correlation ranging between .52 (Case 3 vs Case 4) and .67 (Case 2 vs Case 3). There was therefore no justification for dropping any of the cases from the instrument. Likewise, there was no evidence to suggest that any of the cases generated a fixed response set (agree or disagree). The correlation matrix of items within each case showed that items 1, 3 and 11 ("Given her situation it was the only thing S could do") were highly intercorrelated. The highest correlations were between items 1 and 11. Item 11 also generated the least variance (most respondents tended to "strongly disagree" on all cases). Item 11 was therefore dropped. No other variables were intercorrelated at .50 or more on all four cases. Nevertheless it was decided to amalgamate the two items referring to the subject as victim, since they were intercorrelated significantly on three of the four cases and they appeared to be considerable conceptual overlap between them.

6.5.3 Reliability

Reliability of the Case Vignette instrument was assessed by examining the test-retest stability of each of its constituent scales. Among the re-interviewed respondents, correlations (Pearson r) between interviews for the 36 individual scales ranged from -.070 to .647 with a mean value of .353. Fifteen of the thirty-six scales were not signficantly correlated over the two interviews: M2, JA2, M3, F3, JA3, JO4, M5, JA5, M6, F6, JO6, JA6, M8, JA8, JO9. There

were only two items with significantly different mean scores at the second interview compared to the first: F2 (T = -2.13, 34 d.f., p = .040) and F7 (T = -2.80, 34 d.f., p = .008). None of the items with non-significant correlations had significantly different mean scores between interviews. It was noted that there was a general tendency (of borderline significance) towards greater disagreement at the second interview. Twenty-four out of the 36 items had a higher mean score (i.e. more disagreement) (z = 1.83, .10<p>.05, 2 tail test). This tendency was most pronounced in the case of Frank and for items 6 and 7. Thus, there is evidence of considerable test-retest instability at the individual level, particularly on items 3 and 6, and in relation to cases 'Mary' and 'Jane'. However, test-retest instability may be less extensive than the correlational analysis suggests. On average, sixteen of the thirty-six items were given the same score while a further eleven items were scored within one unit (category), at the second interview in comparison with the first. Once again, group scores were highly stable between interviews.

Changes between interviews in Case Vignette scale scores were correlated with changes in ABS score, in order to examine the influence of change in mood state on the instrument's stability. The only significant findings were in relation to items M1 (r = .51, p = .002), JA3 (r = .36, p = .038) and JA7 (r = .35, p = .042). The relationship between scale scores and ABS score at each interview was also examined. Seven items correlated with ABS score at first interview: F4 (r = .42, p = .014), JO1 (r = .37, p = .030), JO3 (r = .36, p = .036), JO5 (r = .37, p = .030), JO9 (r = .35, p = .042), JA1 (r = .38, p = .026) and JA4 (r = .39, p = .024). At the second interview there were eight such correlations: M9 (r = .34, p = .05), F5 (r = .39, p = .022), JO1 (r = .34, p = .05), JO4 (r = .51, p = .002),

JO5 (r = .43, p = .Ø12), JO6 (r = .47, p = .ØØ6), JO9 (r = .4Ø, p = .Ø18) and JA3 (r = .34, p = .Ø5). This analysis shows that while the individual's mood state does have some influence over scoring on certain items, there is very little consistent pattern in the findings. Only item JO5 is correlated with ABS scores at both interviews. Change in scale scores and change in ABS score were largely unrelated, the number of significant findings being no greater than could be expected by chance alone. We can therefore conclude that little of the instability noted above can be attributed to changes in the individual's mood state.

6.5.4 Validity

The validity of the case vignette instrument has been assessed in a number of ways. Using test-retest reliability as an indirect indicator, we can conclude from evidence presented in the previous section that fifteen items have doubtful validity. That is to say, we can interpret the instability of these items as evidence that their meaning or significance is at the very least somewhat unclear or ambiguous to respondents. It should be noticed that ten of the doubtful items are found in two vignettes ("Mary" and "Jane"), with only two such items in the vignette "Frank". This would make any analysis based on vignettes most unsatisfactory. However, for reasons which will be given below (Chapter 7), the analysis of the data is based on items across cases. Items 1 and 7 have reasonable reliability throughout and only item 6 is unstable on all four vignettes. Thus, results based on items across vignettes should on the whole be reasonably valid, with the possible exception of item 6 (and, to a lesser extent, item 3).

Use of the scales is reported in Tables 6.15, 6.16 and 6.17. Table 6.15 gives the number of respondents in each area x status group exhibiting a possible "mental set" or stereotyped response towards each item separately. The operational definition of "mental set" is no, or only trivial, variance around the mean item score, i.e. no within-rater variation in rating the same item across all four cases. There are few significant inter-group differences in the proportion of respondents with "mental set" and none in relation to items 1, 2, 4, 6, 7 and 8. On item 3, there is significantly more stereotypy among LRA controls than among its matching patient group or than among HRA controls. On items 5 and 9 the HRA patients show less variation in response than the LRA patients. Overall, there is a tendency towards a "set" about items 2 (71% of the total sample giving more or less identical responses across all cases), 7 (64%) and 3 (54%). Nearly half the sample (48.5%) also showed a tendency to give stereotyped responses to item 8. On the other hand, there is little evidence of "set" about items 5 (21.5%), 9 (22%) and 1 (26.5%). In other words, most respondents appear to have a fairly fixed view about whether parasuicide should be punished (item 2), whether it is morally wrong (item 7) or whether it is the right thing to do (item 3). The different circumstances and situations portrayed in the cases tend to have little influence on these opinions. By contrast, there is a considerable variety of opinions expressed by most respondents about whether the particular parasuicide (case vignette) is death-oriented (items 5 and 9) or understandable (item 1).

There is no reason to conclude that evidence of more stereotyped responses to items 2, 3 and 7 is also evidence of these items' invalidity. Although there may be little or no within-rater variation, this does not mean that all respondents rate in the same

Table 6.15 Case Vignette Instrument - Evidence of "mental set"/stereotypical response

Item	LRA		HRA	
	N with "mental set"*		N with "mental set"*	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
1	14	16	10	13
2	39	34	35	34
3	24†	35**†	25	24**
4	17	19	22	17
5	4***	8	18***	13
6	20	22	12	16
7	34	32	31	31
8	20	29	27	21
9	7****	7	17****	13

* "mental set": the respondent gives the same rating to all vignettes on a particular item (i.e. no variance), or an identical rating on three cases while the fourth case is rated only one point more or less on the scale (variance = 0.25).

** $\chi^2 = 4.13$, 1 d.f., $p = .042$

*** $\chi^2 = 9.85$, 1 d.f., $p = .0017$

**** $\chi^2 = 4.44$, 1 d.f., $p = .0351$

† $p = .030$ (2-tail, Binomial Test)

way. Each can have his or her own stereotyped view. Since there are five possible ratings ("strongly agree", "agree", "not sure", "disagree", "strongly disagree") there are five possible types of "mental set". In fact, data presented below (Chapter 7) will show that over the whole sample there were indeed significant differences between vignettes on items 2 and 3. Only item 7 failed to generate both within-individual and between-vignette variation. However, there were significant differences between areas and between statuses in the rating of items 2 and 7, and significant between-statuses differences in the rating of item 3. It should also be noted that the extent of "mental set" is highly variable between items. There would therefore appear to be no warrant for concluding that the tendency towards stereotypy in the rating of items 2, 3 and 7 results from the perceived similarity of the case vignettes. If the meaning of the vignettes was invariant to respondents, then the differentiation between cases found most markedly in responses to items 5, 9 and 1 would be absent. In fact, independent evidence of the between-vignette differences perceived by respondents is found in studies on attitudes towards self-poisoning among physicians and nurses (Ramon et al., 1975) and among psychiatric patients (Hawton et al., 1978). From a list of thirteen suicidal motives respondents were asked to select and rank order the four most relevant to each vignette. (The vignettes used in this study were more or less identical to theirs.) There was clear evidence that the parasuicidal individuals portrayed in the vignettes were seen to have different reasons for their behaviour. Moreover, doctors and nurses made similar distinctions in Ramon et al's study and, as Hawton et al. note (1978: 34), the ranking of motives in their study was "strikingly similar" to that in the previous study, "the first-ranked motive being the same for each of the cases in the two studies".

Since the vignettes have been shown in this and previous studies to possess discriminative validity, the different levels of stereotypy reported in Table 6.15 are held to be important findings rather than evidence of instrument validity.

The evidence of response set among respondents is given in Table 6.16. Overall, and for cases "Mary", "Joe" and "Jane", there is a tendency to disagree with the statements. Responses to case "Frank" are either more evenly balanced between agree and disagree (control groups) or tend towards agreement (patient groups). In the fourth row of Table 6.16 are given the number in each group giving the same response (Agree/Strongly Agree or Disagree/Strongly Disagree) to at least eight items on each of the case vignettes. It can be seen that there is wide variation between groups and between vignettes in the N giving such responses, with a low of one and high of thirteen. Eight or more similar responses out of nine were taken as an indication of response set since this level of bias is significantly different from what could be expected by chance. Likewise, 25 or more similar responses out of 36 (the total N of items over four vignettes) constitutes a significant bias. Thus, overall eight LRA patients, nine HRA patients, sixteen HRA controls and seventeen LRA controls show some evidence of response set (row five of Table 6.16). The differences in proportions of each group showing response set are not significant, although there is a clear trend towards more response set among controls than among patients. However, these figures are almost certainly an over-estimate. In the first place, each category (Agree/Disagree) consists of two ratings which have been amalgamated. Thus, eight "similar" responses may be made up of eight "Strongly Agree" or eight "Agree" or any combination. Only responses which are the same (not those which are merely similar) can strictly be used as

Table 6.16 Case Vignette Instrument - Evidence of response set

(a) L.R.A.

	Patients					Controls				
	Case Vignettes					Case Vignettes				
	Mary	Frank	Joe	Jane	Overall	Mary	Frank	Joe	Jane	Overall
Mean n of items scored "Strongly Agree" or "Agree"	3.4	4.8	3.6	3.1	3.7	2.8	3.7	2.9	2.5	3.0
Mean n of items scored "Not Sure"	0.7	0.6	0.6	0.8	0.7	0.3	0.4	0.5	0.4	0.4
Mean n of items scored "Strongly Disagree" or "Disagree"	5.0	3.6	4.8	5.1	4.6	5.9	4.9	5.6	6.0	5.6
N of respondents giving same response to ⩾ 8 items on each case	6 (1 A*) (5 D**)	3 (2 A*) (1 D**)	7 (1 A*) (6 D**)	7 (2 A*) (5 D**)	n.a.	9 (9 D**)	2 (2 D**)	11 (1 A*) (10 D**)	13 (13 D**)	n.a.
N of respondents giving same response to ⩾ 25 items over all cases	n.a.	n.a.	n.a.	n.a.	8 (2 A*) (6 D**)	n.a.	n.a.	n.a.	n.a.	17 (17 D**)

* A = Agree
** D = Disagree

Table 6.16 continued ...

(b) H.R.A.

	Patients					Controls				
	Case Vignettes					Case Vignettes				
	Mary	Frank	Joe	Jane	Overall	Mary	Frank	Joe	Jane	Overall
Mean n of items scored "Strongly Agree" or "Agree"	3.4	4.4	3.4	3.5	3.7	3.0	4.2	3.3	3.3	3.4
Mean n of items scored "Not Sure"	0.9	0.9	0.9	0.7	0.9	0.4	0.4	0.4	0.4	0.4
Mean n of items scored "Strongly Disagree" or "Disagree"	4.6	3.7	4.7	4.8	4.4	5.6	4.4	5.3	5.4	5.2
N of respondents giving same response to ⩾ 8 items on each case	5 (1 A*) (4 D**)	1 (1 A*)	5 (5 D**)	7 (2 A*) (5 D**)	n.a.	13 (1 A*) (12 D**)	5 (3 A*) (2 D**)	9 (3 A*) (6 D**)	8 (8 D**)	n.a.
N of respondents giving same response to ⩾ 25 items over all cases	n.a.	n.a.	n.a.	n.a.	9 (4 A*) (5 D**)	n.a.	n.a.	n.a.	n.a.	16 (2 A*) (14 D**)

* A = Agree
** D = Disagree

evidence of response set. Secondly, since the overall trend in responses is towards disagreement, the number of similar "disagree" ratings taken to be evidence of response set should be adjusted accordingly. To give an example, if the criterion of response set is similar ratings on $\geqslant$28 items, then the numbers in each group who give evidence of responding in a set fashion are as follows: LRA patients, 3; LRA controls, 9; HRA patients, 2; HRA controls, 7. Of this total of 21, all but two have a tendency to disagree. It can therefore be concluded from this analysis that there is little evidence of response set, and where response set appears likely it tends to be negative (denial), not positive (acquiescence).

Some data on the use of the 'Not Sure' category are also given in Table 6.17. Although there appear to be no differences in the mean number of items rated 'Not Sure' between patient groups or between control groups, both patient groups rate the item more often than their matched controls. Table 6.17 shows the number of respondents in each group rating Ø, 1, 2, 3, 4, 5, $\geqslant$ 6 items (out of 36) 'Not Sure'. Only the differences in the HRA are significant ($p<.Ø5$, Wilcoxon Matched-Pairs Test). Analysis of 'Not Sure' responses by vignette shows that each generated a similar number of such responses. However, 'Not Sure' responses were not randomly distributed across items (χ^2 one-sample test: $\chi^2 = 47.5$, 8 d.f., $p<.ØØ1$). Considering all respondents, the percentage of the total number of 'Not Sure' responses given to each item was as follows: Item 1, 12.5%; item 2, 5.9%; item 3, 1Ø.1%; item 4, 12.1%; item 5, 14.2%; item 6, 16.9%; item 7, 1Ø.1%; item 8, 5.3%; item 9, 12.9%. Thus, nearly a third of all 'Not Sure' responses were found on items 5 and 6. While patient groups in the two areas tended to give the most 'Not Sure' responses to the same items, and the two control

Table 6.17 Case Vignettes - Use of 'Not Sure' Category

Number of items rated 'Not Sure'	LRA		HRA	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
0	20	31	19	31
1	5	4	8	2
2	6	5	2	6
3	3	0	4	2
4	4	2	2	2
5	3	2	3	2
⩾ 6	9	6	12	5
TOTALS	50	50	50	50
Mean n of items rated 'Not Sure'	2.68	1.62	3.52	1.64
(S.D.)	(3.47)	(2.85)	(4.98)	(2.88)

groups did likewise, patients and controls differed considerably from each other (r_s = Ø.Ø7, n.s.). Patients gave the most 'Not Sure' responses to items 6, 5, 1 and 3, controls to items 7, 4, 9 and 6.

These findings on the distribution of 'Not Sure' responses are similar to those relating to the WOBI. In both cases, there has been a tendency for homogeneity among patients and among controls in respect of the extent of 'Not Sure' responses, but markedly more such responses among patients than among their matched controls. However, whereas there was a tendency for patients and controls to agree on the WOBI about which items were the most difficult to rate, there was no such agreement on the Case Vignette Instrument. Since the WOBI items which generated most 'Not Sure' responses were those concerning suicide and attempted suicide, it is not altogether surprising that, when the meaning of suicidal behaviour was explored in depth in the Case Vignette Instrument, patient-control differences were found both in overall item scores and in the distribution of 'Not Sure' responses.

6.6 Contact with Suicidal Behaviour (CSB)

6.6.1 Description

This instrument was devised as a means of providing data on previous exposure to suicidal behaviour, in order to establish the relationship between such contact, on the one hand, and attitudes towards, and perceptions of, parasuicide, on the other. The CSB is a semi-structured schedule which is completed by the interviewer. It is printed in full in Appendix 6.8. Information is sought about three classes of suicidal behaviour: threat, parasuicide and

completed suicide. Respondents were asked if they had been personally involved or had only heard about the incident indirectly. ("Personal involvement" was strictly defined: see Appendix 6.8). In the case of threat and parasuicide, the number of events and the number of persons were rated separately. The date of the incident and the relationship of the suicidal individual to the respondent was also noted. In order to guard against exaggerated claims of contact with suicidal behaviour and to increase the reliability of the report, respondents were requested to give some biographical and contextual information about each contact. They were also expected to be able to "put a name to a face", although, for reasons of confidentiality, no names were sought or given. All respondents, patients and controls, were questioned about their contact with suicidal behaviour; there are no missing data.

6.6.2 Pre-test procedures

The CSB was piloted on twenty parasuicide patients and ten members of staff at the RPTC, at the same time as the VOS (see above). The instrument appeared acceptable and I experienced no difficulties in completing the ratings. The final version used in the main study is substantially the same as that used in the pilot run, except for minor amendments in layout and a clearer definition of "personal involvement".

6.6.3 Reliability

The 35 respondents who were followed-up in the main study were questioned about contact with suicidal behaviour on both occasions. Consistency of responses was extremely high. Only two respondents

(two patients) made reference at the follow-up to a contact with suicide which was not mentioned at the first interview. Six (three patients, three controls) failed to mention a contact which was noted at the first interview. However, in no case did the contact concern a close friend or relative or personal involvement. In five of the six cases, the contact had been more than one year previously. The information given therefore appears to be fairly reliable, with no differences noted in the stability of responses between patients and controls.

6.6.4 Validity

There was no possibility of making a systematic check on the factual accuracy of all the information given by all respondents. However, patients admitted to the RPTC were routinely asked by the psychiatrist whether any near relative had committed parasuicide or suicide. Although the patient was the source of information about such contact for the psychiatrist and in my study, the differences in the circumstances of the interview (hospital vs home), its timing (within hours of the parasuicide vs days later) and the interviewer making the ratings (various psychiatrists vs author) mean that agreement between the two sets of data is as much a measure of validity as of reliability. Agreement between RPTC and myself (SP) on self-poisoning by a near relative is presented in Table 6.18. While overall agreement was acceptably high at more than 90%, there were considerable discrepancies in rating both items present. The findings for parasuicide in a near relative are not altogether surprising. Six patients told me about such episodes but witheld information from the RPTC psychiatrist. Two of the patients said that they had acted in this way deliberately; presumably the other

Table 6.18 Agreement between author and RPTC on completed suicide by near relative of patient

		Author's rating of completed suicide		
		No	Yes	TOTALS
RPTC rating of completed suicide	No	94	0	94
	Yes	5	1	6
	TOTALS	99	1	100

Overall agreement = 95%

Index of agreement (present) = 16.7%

Index of agreement (absent) = 94.9%

four forgot or were mis-coded on this variable. I am assuming that the information given to me is more accurate, since the patient is more likely to conceal a family history of parasuicide when asked a cursory question than invent such a history when subjected to close and detailed probes. The stability in reports over time supports this assumption. The disagreement over completed suicide in a near relative (Table 6.19) is in the other direction. According to the RPTC records there are six patients in this series with a family history of suicide; according to my data, only one. In two of the five discrepant cases the RPTC data are definitely incorrect. A spouse and a parent had "attempted" but not committed suicide. I personally met the two supposedly deceased persons. It is not possible to state definitely which data set is correct with respect to the other three cases (numbers ØØ1, ØØ9, Ø8Ø). However, all three are rated "other combination", i.e. at least <u>two</u> suicides among close family members. When asked by the author, case ØØ1 denied any contact at all with suicide; case ØØ9 reported that her mother constantly threatened suicide, her grandmother attempted suicide and her uncle committed suicide; case Ø8Ø reported that both her grandmother and uncle had committed suicide. It is most unlikely that cases ØØ9 and Ø8Ø have concealed at least two other suicides in near relatives: more likely the psychiatrist has misunderstood the category "other combination" and rated these suicides of non-near relatives in error. In addition, case ØØ9 was one of the discrepant cases on the rating of previous parasuicide by the patient. The evidence, then, firmly points to the greater accuracy of the author's data. There were probably not more than a couple of rating errors for each variable. If these findings hold throughout the CSB instrument (and we cannot say definitely whether they do or do not), then the results will have an extremely high level of validity.

Table 6.19 Agreement between author and RPTC on episode of self-poisoning by near relative of patient

		Author's rating of previous self-poisoning		
		No	Yes	TOTALS
RPTC rating of previous self-poisoning	No	84	6	90
	Yes	1	8	9
	TOTALS	85	14	99

1 case missing (Rated 'Not Known' by RPTC)

Overall agreement = 92.9%

Index of agreement (present) = 53.3%

Index of agreement (absent) = 92.3%

6.7 Psychological Well-Being Scale (PWB Scale)

This scale, presented in Appendix 6.9, measures avowed happiness or the feeling of psychological well-being. It was devised by Bradburn (Bradburn, 1969) and consists of ten questions concerning feelings the respondent may have had over "the past few days". The questions used in this study are identical to Bradburn's. Five measure positive affect (Q2, Q4, Q6, Q7, Q8) and five, negative affect (Q1, Q3, Q5, Q9, Q10). Each is scored 1 for a "yes" answer, zero for a "no" answer. The Positive Affect Scale (PAS) is constructed by aggregating scores for the positive items, the Negative Affect Scale (NAS) by aggregating scores for negative items. The Affect Balance Scale (ABS) score is constructed by subtracting the NAS score from the PAS score and adding a constant of 5. Thus, the ABS scale has a range of 0-10, 0 consisting a complete absence of positive affect and maximum negative affect, while 10 means absence of negative effect and maximum positive affect. Bradburn shows that the PAS and NAS scales do not occupy two polar positions on a single dimension but are two separate dimensions which vary independently of each other. Bradburn concludes that the ABS score (i.e. the difference between the two scales) is strongly related to an individual's current level of happiness. An individual's subjective sense of well-being can be seen as the relative strength of his feelings of pleasure over pain in day-to-day living. Extensive use has been made of Bradburn's scale in survey research; comments on the reliability and validity of the scale, as well as the distribution of scores in various samples of individuals, have been described elsewhere (see, e.g. Ogden and Bradburn, 1968; Bradburn, 1969; Berkman, 1971).

In this study the questions were asked by the interviewer and the answers noted. Positive and negative items were randomly distributed in order to guard against response set. Thirty-four respondents were rated twice on the PWB scale. (One respondent who was followed-up was not administered the PWB scale at the second interview through an oversight.) Evidence of the construct validity of the scale is given by the finding that over the eleven week period between interviews, the patient group improved significantly in their ABS score ($p = .002$, 2 tailed T-Test) while the control group experienced no change ($p>.4$). At the time of the first interview the patient group's ABS score was significantly lower than the control group's ABS score ($p<.01$), but at the second interview there was no significant difference between patients and controls. Previous research (e.g. Newson-Smith and Hirsch, 1979) has shown a similar reduction in psychiatric symptomatology among parasuicide patients over three months, while a control group of hospital employees were unchanged in their mean GHQ score. The finding of no difference in ABS score between patients and controls at the follow-up interview, although not predicted by previous work, was unsurprising. At the first interview I also found an absence of correlation between NAS and PAS scores in the whole group, ($r = -.07$, $p>.7$) and among patients ($r = .14$, $p>.6$) and controls separately ($r = -0.04$, $p>.8$). The total ABS score was significantly correlated in a negative direction with the NAS score and in a positive direction with the PAS score. These findings were in accordance with Bradburn's predictions and results.

Chapter 7 MAJOR HYPOTHESIS TESTED: COMPARISON OF CONTROL GROUPS

7.1 Major hypothesis restated

The major hypothesis of the present investigation has already been stated in Chapter 4, as follows:

> Areas with high parasuicide rates (HRAs) are also characterised by a distinctive subculture. This subculture, maximally expressed among the working class living in a predominantly working-class area, is held to be distinct from the dominant local culture, although not in every respect. Its system of values, norms and beliefs facilitates and permits the form of behaviour labelled parasuicide to a considerable degree.

The null hypothesis states that high-rate parasuicide areas and low-rate parasuicide areas are characterised by similar cultural meaning systems; and that there is therefore no association between subculture and incidence of parasuicide.

In Chapter 4 middle-order hypotheses relating to the various dimensions or elements of subculture were also set forth. These can now be broken down further into hypotheses relating to the individual measures and instruments described in Chapter 6. They are presented below in the form of predictions relating to individual items or clusters of items. Comparisons throughout are between the two control groups, for reasons already stated in Chapter 5.

7.2 Predictions relating to the various research instruments

7.2.1 Background Data Schedule

Strictly speaking, the Background Data Schedule was not intended to measure cultural elements per se. However, the instrument included questions designed to assess the extent of attachment to the local area (Community Sentiment Scale) and of contact with family, friends and neighbours in the local area (Local Bonds Scale). The expected differences between areas on these scales will be shown to have a direct bearing on the characterisation of the HRA subculture (see Chapter 9).

Scale	Prediction
Community Sentiment Scale	Significantly more attachment to the local area shown by LRA respondents
Local Bonds Scale	Significantly more extensive social network in the local area among HRA respondents

On the socio-demographic items, it was hoped that the two area control groups would not differ in respect of age, sex and marital status, but would show significantly different profiles on variables relating to socio-economic position and social status - e.g. social class, educational qualifications, housing tenure and net income.

7.2.2 Value Orientation Schedule

Predictions were not attempted for each item on this instrument, but for clusters of items forming a particular value orientation. Different total orientation patterning was expected, as follows:

Orientation	Pattern in HRA	Pattern in LRA
Activity	Doing > Being	Being > Doing
Relational	Collateral > Individualistic > Lineal	Individualistic > Collateral > Lineal
Time	Present > Future > Past	Future > Present > Past
Man-Nature	Subjected > Over > With	Over > Subjected > With
Human-Nature	Pessimistic > Optimistic	Optimistic > Pessimistic

(">" signifies "preferred to a significantly greater degree than". Thus, on the Relational value orientation, it is predicted that HRA controls will consider the Collateral alternative to be more desirable than the Independent alternative, which itself is preferable to the Lineal alternative. Among LRA controls, the Independent alternative is predicted to be the first choice, followed by the Collateral alternative, with the Lineal alternative again the least preferred choice.)

These predictions represent extreme ideal-type responses. Actual differences were expected to be less sharply defined in accordance with our assumptions that the two area types were subcultures rather than contracultures. More realistic hypotheses relating to the eleven individual dimensions of the VOS were as follows. They are based on the expectation of differences in degree

between HRA and LRA groups, rather than differences in kind. (The sources for all the predictions in this section are given in Chapter 4, Table 4.2.)

Dimension	Prediction
[Doing, Being]	HRA shows stronger tendency to score towards the Doing pole
[Lineal, Collateral]	HRA shows stronger tendency to score towards the Collateral pole
[Lineal, Individualistic]	HRA shows stronger tendency to score towards Lineal pole
[Collateral, Individualistic]	HRA shows stronger tendency to score towards Collateral pole
[Past, Present]	HRA shows stronger tendency to score towards Present pole
[Past, Future]	HRA shows stronger tendency to score towards Past pole
[Present, Future]	HRA shows stronger tendency to score towards Present pole
[Subjected, With]	HRA shows stronger tendency to score towards Subjected pole
[Subjected, Over]	HRA shows stronger tendency to score towards Subjected pole
[With, Over]	HRA shows stronger tendency to score towards With pole
[Pessimistic, Optimistic]	HRA shows stronger tendency to score towards Pessimistic pole

In all cases, the null hypothesis states that there will be no difference between HRA and LRA control groups on dimension scores.

7.2.3 Ways of Behaving Instrument

Predictions relating to individual items of each section of the WOBI are as follows. (The null hypothesis in each case is of no difference in scores on any item between HRA and LRA control groups.) The predictions are again couched in terms of a greater tendency towards one or other pole of a continuum among one group compared to another, rather than in terms of absolute differences. (For the sources of the hypotheses, see Chapter 4, Table 4.3. Items 1, 2 and 4 tap the non-deferred gratification pattern; items 3, 9, 11 and 19 conflict and violence in family relationships; items 5 and 15, problem-solving and -sharing; item 7 and 17, traditional sex-role behaviour/patriarchy; item 10, integration into society; items 8, 12 and 13, toughness and trouble; items 14 and 18 tap use of alcohol and drugs.)

Evaluation

1. LRA feels that the married couple should put aside money to greater extent than HRA.
2. LRA feels that child should not leave school at 16 to greater extent than HRA.
3. LRA feels that married couple should not quarrel and row to greater extent than HRA.
4. LRA feels that young person should not have sex before marriage to greater extent than HRA.
5. LRA feels that person should confide problems to greater extent than HRA.
6. LRA feels that person should not commit suicide to greater

extent than HRA.

7. HRA feels that married woman with young children should not go out to work to greater extent than LRA.
8. LRA feels that man should not get into fights in the street to greater extent than HRA.
9. LRA feels that parents should not severely beat children to greater extent than HRA.
10. LRA feels person should vote in general election to greater extent than HRA.
11. HRA feels that unhappily married couple should get divorce or separation to greater extent than LRA.
12. LRA feels that young person should not take car for joyride to greater extent than HRA.
13. LRA feels that adult should not settle argument with fists to greater extent than HRA.
14. HRA feels that person should get pills from doctor when feeling nervy/depressed to greater extent than LRA.
15. LRA feels that couple should share worries with each other to greater extent than HRA.
16. LRA feels that person should not harm him/herself deliberately to greater extent than HRA.
17. LRA feels that husband should help about the house to greater extent than HRA.
18. LRA feels that man should not get drunk when he goes out with friends to greater extent than HRA.
19. LRA feels that husband should not batter his wife to greater extent than HRA.

Expectation

Item	Behaviour more or less likely in HRA?
1	Less likely
2	More likely
3	More likely
4	More likely
5	Less likely
6	More likely
7	More likely
8	More likely
9	More likely
10	Less likely
11	More likely
12	More likely
13	More likely
14	More likely
15	Less likely
16	More likely
17	Less likely
18	More likely
19	More likely

In addition to these predictions of inter-group differences at the individual level, two further hypotheses can be derived from the discussion in Chapter 4:

(1) There is a greater tendency for scores to be nearer the "May or May Not" mid-point of the Evaluation scale in HRA compared to LRA. (This is an operationalisation of

the notion of more permissive attitudes in the HRA.)

(2) The HRA is likely to have significantly lower Evaluation scores (i.e. more tolerant attitudes) on items 6, 8, 9, 12, 13, 16, 18 and 19. (This is an operationalistion of the hypothesis of more toleration of deviance in general in the HRA.)

Finally, it can also be predicted that there will be greater consensus within the HRA group on the evaluation and expectation of behavioural items, compared to the LRA. This prediction follows from our conceptualisation of subculture. (See the previous discussion in Chapter 6, section 6.4.1, and also Chapter 9 below.)

7.2.4 Case Vignette Instrument

The following hypotheses are proposed in relation to the Case Vignette Instrument. In all cases, the null hypothesis is of no inter-group differences on any measure. (For the source of the hypotheses, see Chapter 3.)

Item	Prediction
1	Behaviour is seen as more understandable in HRA.
2	Behaviour is seen as less sanctionable in HRA.
3	Less strong disagreement in HRA that behaviour is "right".
4	Behaviour is seen to be beyond the subject's control to a greater extent in HRA.
5	General tendency for HRA to disagree more than LRA that S "wanted to die".

6 HRA more in agreement with statement (that "any man/woman might do what S did") than LRA.

7 Behaviour seen as more morally wrong in LRA.

8 HRA disagrees less than LRA that behaviour was a possible way of dealing with problems.

9 General tendency for HRA to disagree more that S "intended to commit suicide".

A further more general prediction concerns the extent of consensus on these attitudinal measures: it is expected to be higher in the HRA than in the LRA.

Three additional hypotheses will also be examined in this Chapter. Two relate to the whole control population and arise out of methodological, rather than substantive, concerns:

1. Items are distinct and tap different features/aspects of the situation.
2. Vignettes are distinct and evoke different responses.

The third hypothesis is formulated in the belief that differentiation of cases falling under the rubric "parasuicide" will be more extensive in the area where such behaviour is more frequent.

3. There will be a tendency for HRA controls to make finer distinctions between vignettes than LRA controls.

7.2.5 Contact with Suicidal Behaviour

The following hypotheses are proposed in relation to this instrument. The null hypothesis throughout is that the HRA and LRA control groups do not differ on any measure.

1. Contact with threatened suicidal behaviour is more widespread in HRA.
2. Contact with parasuicide is more widespread in HRA.
3. Contact with suicide is more widespread in HRA.
4. Overall contact with all forms of actual and threatened suicidal behaviour is more widespread in HRA.
5. Contact with suicidal behaviour in a close friend or relation is more widespread in HRA.
6. Contact with suicidal behaviour in non-close friend/relative is more widespread in HRA.
7. Personal involvement in suicidal behaviour is significantly greater in HRA.
8. In general, the greater the contact with suicidal behaviour, the more favourable will be the evaluation of the behaviour.

Throughout, "contact" is a life-time measure.

7.3 Statistical tests

For the purposes of analysis, the control groups are treated as independent random samples of area populations, stratified by age, sex and area of residence. Although each control is matched pairwise with a parasuicide patient, the LRA and HRA patient groups are independent, and the choice of controls is random within the constraints of the matching procedure. All statistical tests in this Chapter are chosen on the assumption that HRA and LRA control groups constitute independent samples. For categorical data, the χ^2 test is applied to check for all significance of differences between groups. Where 2x2 contingency tables are analysed, the χ^2 value is that which has been corrected using Yates' formula (see, e.g. Siegel, 1956:

1Ø7). Measures which are based on continuous data are assumed to possess the qualities of an interval scale. Where all the conditions of the parametric statistical model are fulfilled (i.e. independent observations, observations drawn from normally distributed populations, homoscedasticity), the T-Test is applied to the mean scores of both groups to test for the significance of differences. Nonparametric tests (usually the Mann-Whitney U Test) are used if the assumption of equal variances across groups is violated. However, it frequently happens that parametric and nonparametric tests applied to this kind of data produce results which are effectively identical, i.e. the probabilities or significance values associated with the T score or U score do not differ to any marked degree. Where this is the case, only the T-Test analysis is reported. Throughout, the significance level (α) is set at .Ø5, and sample sizes are 5Ø in each group. Although some hypotheses state the direction of a predicted difference between groups (and therefore the region of rejection is one-tailed), two-tailed significance tests are used for all analyses. In effect, this ensures a somewhat conservative approach to the evaluation of inter-group differences. The region of rejection for all hypotheses consists then of all values of T (or U or whatever) which are so small that the probability associated with their occurrence under H is equal to or less than .Ø5. (See also section 7.5.1 below for methods of statistical analysis in relation to the VOS.)

7.4 Demographic and Social Characteristics of Control Groups

The social and demographic characteristics of the LRA and HRA control groups are presented in Table 7.1. The groups differed significantly in education (LRA controls more educated); social class

Table 7.1. Social and demographic characteristics of control groups

Variable	LRA (N=50)	HRA (N=50)	Significance of intergroup difference (χ^2/T-Test)
Mean age ..... years (S.D.)	30.5 (12.4)	29.5 (11.1)	n.s.
Sex			
Male	21	18	n.s.
Female	29	32	
Marital status			
Single	19	15	
Married/cohabiting	31	30	n.s.
Separated/divorced/widowed	0	5	
Time married/cohabiting			
⩽ 5 years	9	9	
6-10 years	6	9	
⩾ 11 years	15	12	n.s.
Not known	1	0	
(Not applicable)	(19)	(20)	
Religion			
Protestant	40	37	
Catholic	3	6	n.s.
Other	4	1	
None	3	6	
Churchgoing			
At least weekly)	9) 16	3) 3	χ^2 = 13.50, 2 d.f. p = .0012
At least monthly)	7)	0)	
At least once a year	11	8	
Never	23	39	
Birthplace			
Scotland	44	48	n.s.
Elsewhere	6	2	
Place where childhood spent			
Scotland	44	47	n.s.
Elsewhere	6	3	
Present employment status			
Working	37	33	
Unemployed	0	2	
Retired	1	1	n.s.
Housewife only	5	13	
Student	7	1	

Table 7.1. continued ...

Variable	LRA (N=50)	HRA (N=50)	Significance of intergroup difference (χ^2/T-Test)
Number of jobs over past 5 years (including present one)			
1	20	18	
2	13	13	n.s.
⩾3	8	14	
(Not applicable/Not Known)	(9)	(5)	
Education			
In education	7	1	χ^2 = 24.22,
No qualifications	18	42	2 d.f.
Some qualifications	25	7	p<.0001
Objective social class			
I)	11)	0)	
II)	20)41	4)11	χ^2 = 33.69,
III NonManual)	10)	7)	1 d.f.
III Manual)	5)	15)	p<.0001
IV)	2) 9	17)39	
V)	2)	7)	
Subjective social class			
Lower)	1)	3)	
Working)	17)18	35)38	χ^2 = 16.52,
Middle	27	11	2 d.f.
Other (combination of above))	2)	0)	p<.001
"None")	3) 5	0) 1	
"Don't Know")	0)	1)	
Household type			
Living with spouse/cohabitee	31	30	
Living with parent(s)	17	14	
Living with child(ren)	0	6	n.s.
Living with other relative/ friend	1	0	
Living alone	1	0	
Type of tenure			
Owner-occupied	40	5	χ^2 = 46.71,
Rented from corporation)	7)	45)	1 d.f.
Rented from private landlord)	2)10	0)45	p<.0001
Lodgings)	1)	0)	
Density			
⩽ 1.5 persons per room	49	43	n.s.
> 1.5 persons per room	1	7	

Table 7.1. continued ...

Variable	LRA (N=50)	HRA (N=50)	Significance of intergroup difference (χ^2/T-Test)
Time at present address			
⩽ 3 months	0	0	
4-12 months	7	3	
1-5 years	15	18	n.s.
Over 5 years	28	29	
Mean length of time at present address ..... months (S.D.)	112.4 (112.6)	116.2 (89.5)	n.s.
Previous address			
Same ward	15	18	
Other ward in Edinburgh	21	23	
Elsewhere in Scotland	5	2	n.s.
Outside Scotland	6	2	
(Not applicable - born in house)	(3)	(5)	
Number of addresses in past 5 years (including present one)			
1	29	29	
2	10	12	n.s.
⩾3	11	9	
Mean net income (£) per person in household per week (S.D.)	£40.58 (16.89)	£25.64 (15.18)	T = 4.52, 92 d.f. p<.001

(majority of LRA controls being in nonmanual occupations and assigning themselves subjectively to the middle class, whereas majority of HRA controls in manual occupations and assigning themselves to the working or lower classes); type of tenure of housing (80% of LRA controls in owner-occupation compared to only 10% of HRA controls); mean income per person in household (60% higher in LRA); and church-going (more frequent in LRA). The modal control in both areas was aged 30, married, working, nominally Protestant, born and brought up in Scotland, and a long-term resident in their community.

The individual's relationship to the local area is markedly different in the two area-types. Table 7.2 shows that overall HRA controls have significantly more friends and relatives available to them in their local area than do LRA controls. While the two groups did not differ significantly in the number of acquaintances and friends living locally, HRA controls had an average over three times as many relatives on hand. It was this striking difference which contributed most to the significant inter-group difference on the Local Bonds Scale.

On the other hand, LRA controls manifested significantly more community sentiment than did their HRA counterparts. Table 7.3 shows that the LRA group felt more at home in the area ($p = .056$), were significantly more satisfied about the area, would feel more sorry if they had to move away, and were less likely to move anyway in the near future. The Community Sentiment Scale score is over 50% higher in the LRA than in the HRA (a difference significant beyond the .1% level).

Table 7.2. "Local Bonds": Control Groups Compared

Variable	LRA (N=50)	HRA (N=50)	Significance of inter-group difference (χ^2/T-Test)
How many people do you know in the area?			
None	0	1	
"Few" (≤6)	10	14	n.s.
"Lot" (>6)	40	35	
Mean N. of friends in the area (S.D.)	1.40 (1.87)	2.04 (2.83)	n.s.
Mean N. of relatives in the area (S.D.)	0.84 (1.70)	2.84 (2.44)	T = 4.77, df 87.43, p<.001
Local Bonds Scale* Score			
0	0	1	
1	30	5	
2	17	35	
3	3	9	
Mean Score (S.D.)	1.46 (0.61)	2.04 (0.61)	T = 4.76, df 98, p<.001

* For calculation of scale score, see Chapter 6.

Table 7.3. "Community Sentiment": Control Groups Compared

Variable	LRA (N=50)	HRA (N=50)	Significance of inter-group difference (χ^2/T-Test)
Do you feel at home/ belong in the area?			
No	4	12	(χ^2 = 3.65,
Yes	46	38	1 d.f., p=.056)
Is there a sense of community in the area?			
None	34	34	
Some	10	6	n.s.
A lot	4	8	
(Don't know)	(2)	(2)	
Feelings about the area?			
Satisfied	44	22	χ^2 = 19.65,
"Don't mind")	2) 6	2) 28	1 d.f.,
Dissatisfied)	4)	26)	p<.001
Interest in the area			
None	26	32	
Some	15	12	n.s.
A lot	9	6	
How would you feel if you had to move away?			
Not sorry	13	26	
Quite sorry)	7)	6)	χ^2 = 8.90,
Very sorry)	18) 25	6) 12	2 d.f.,
Depends ...	12	12	p=.0117
Do you plan to move from area in near future?			
No	37	26	χ^2 = 12.25,
Possibly	8	4	2 d.f.,
Yes	5	20	p=.0022
Community Sentiment Scale* score			
0	0	8	
1	4	10	
2	5	12	
3	18	12	
4	23	8	
Mean Score (S.D.)	3.20 (0.93)	2.04 (1.32)	T = 5.08, df 87.67, p<.001

* For calculation of scale score, see Chapter 6.

7.5 Value Orientation Schedule: findings

7.5.1 Method of statistical analysis

The selection of methods of data analysis centres upon two basic questions, that is, the existence (or non-existence) of uniformities in the ranking of the orientation alternatives within each group (subculture); and the existence (or non-existence) of differences in these uniformities between groups (subcultures). Unfortunately, the questions of within-subculture and between-subculture differences are themselves complex and there seems to be no simple or single means of analysing the data for finding the answers to them. Some extended discussion of the analytical methods finally adopted is therefore necessary. (The argument closely follows that of Kluckhohn and Strodtbeck, 1961: 121-137).

The approach to determine within-group regularities involves three analytic steps. (1) The most crucial test is that of ascertaining whether or not there is a statistically significant ordering of alternatives in the responses given to the individual items in a particular group. (2) In addition, we require to know the degree of statistical significance between the choices within the ordering, and (3) to go beyond the item ordering and test for the significance of the overall or summary patterns of the ordering of the alternatives for a total series of items. Once these three questions have been answered, we can seek to answer the fourth major question, namely, the degree of between-group difference.

The formal statistical phrasing of the four questions may be

given in null form as follows:

(1) After members of a group (subculture) have ranked the alternatives in a single value-orientation item, how likely is it that the resultant pattern of responses could have occurred if, among the members of the group, there were no preferences for some ranking patterns rather than another? (Can the resulting pattern be explained by chance variation alone?)

(2) After members of a group have ranked the alternatives in a single value-orientation item, how likely is the pattern of paired alternative responses if they do not prefer one particular alternative to a second particular alternative in their responses to the items?

(3) After all members of a group have ranked the alternatives to all the items in a value-orientation series, how likely is the total pattern of responses if they do not prefer the alternatives in that series which represent one particular value-orientation position to those which represent a second particular position?

(4) After members of each group have ranked the alternatives to all of the items in a value-orientation series, how likely are the patterns of responses from each of the groups if the members of those groups do not differentially prefer the alternatives in that series which represent one particular value-orientation position to those which represent a second particular position. (Again, can its resulting pattern be explained by chance alone?)

These four questions will be discussed in order, outlining the

statistical techniques employed to implement them.

(1) Within-group regularity on a single item from the VOS

I begin by considering the ranking operation expected of informants when they deal with a three-alternative item from the VOS. The respondent is asked to rank the alternative from most preferred (rank = 1) to least preferred (rank = 3). (This discussion is confined to the three-alternative items since the two-alternative case is easily handled by binomial methods.) If such alternatives are designated A, B and C, then (excluding cases of a tie) one of the following patterns is possible (where ">" means "is preferred to").

A > B > C	A > C > B	B > A > C
B > C > A	C > A > B	C > B > A

After such ranking is completed, the number 1 (one) is assigned to the first choice, 2 (two) to the second choice, and 3 (three) to the third choice. When a group of respondents have ranked the alternatives to an item, we sum the numerical assignations to the alternatives across informants to assess the consensus among them. In the most null case each of the alternative ways of ranking is equally likely to occur. This is taken as the null hypothesis. With this null hypothesis, except for sampling fluctuations the sum across respondents for alternative A equals the sum for alternative B equals the sum for alternative C (A = B = C). The discrepancy of the actual sums from the theoretical null sums is the quantity we deal with in order to determine whether or not the degree of observed consensus is a chance occurrence or not. These discrepancies, squared and summed, are Kendall's S, the statistic whose known

probability distribution under the null hypothesis allows us to test our level of consensus. (See Kluckhohn and Strodtbeck (1961: 125-7) for an example of the use of this technique; Siegel (1956: 229-238) contains a useful discussion of the Kendal Coefficient of Concordance and the S statistic from which it is derived.)

(2) A binomial analysis of alternative preferences within groups

Still utilising a single item from a single value-orientation series, this question concerns itself with the relative popularity of each of the particular alternatives within that item which the respondent is asked to rank order. Even when we have decided whether or not a non-chance preference patterning of rank orders exists among a group of persons on a particular question, we wish to know more about the differences between alternatives in terms of their individual popularity. Having rejected the null hypothesis A = B = C, visual inspection of the data might suggest that A is preferred to B and B in turn is preferred to C. But how can this be tested? In statistical terms, having rejected a general null hypothesis, what new information do our three more specific null hypotheses (A = B, A = C, B = C) yield?

By dealing with frequencies expressing the preferential patterning within pairs of alternatives in turn, we can produce most of the needed information. Let us designate three pairs of alternatives: [A, B], [A, C] and [B, C]. We then count the number of times each is preferred to the other, within each pair, over the entire group. We define "preferred to" as follows: For any pair of alternatives A and B, A is preferred to B if (1) A is assigned rank 1, B rank 2; or (2) A is assigned rank 1, B rank 3; or (3) A is

assigned rank 2, B rank 3. In case of tied ranks, we count A's preference to B as half and B's preference to A as half.

To assess the probability that each of these frequencies would have arisen by chance if the null hypothesis of no preference between alternatives within a single pair is true, we evaluate them against a normal-curve approximation to a binomial distribution. How many persons out of groups of size 50 (m = 50) must prefer one alternative to another for us to reject this hypothesis? To find out, we solve the equation:

$$z = \frac{f - E - .50}{\sqrt{m\,(p)\,(q)}}$$

where:

z = a unit normal deviate,

f = the observed frequency of persons preferring A to B,

E = the expected frequency of persons preferring A to B,

.50 = a correction for continuity,

p = the expected proportion of persons preferring A to B,

q = the expected proportion of persons preferring B to A, and

m = the number of persons in the sample,

by setting z = 1.96 (for the .05 level of significance, two-tailed test) and filling in the known values. The result for our control groups (where m = 50 in both cases) is f = 33. Since we are using a two-tailed test of significance, we can reject the null hypothesis of no preference between two alternatives when one is preferred to the other <u>either</u> 33 or more times <u>or</u> 17 or fewer times. Note that only preferences <u>within pairs of alternatives</u> can be identified. For example, suppose we find A > B at the .05 level, and A > C at the .05 level and B > C at the .05 level. Though we can hold that <u>each</u>

of these preferences holds, we cannot conclude that A > B > C as a total pattern holds. However, by making the three comparisons we exhaust the possibilities for any single ranking; hence little difficulty ensues in drawing conclusions about the internal patterning of responses to the whole item, for certain purposes, if this caution is kept in mind.

In order to describe the results of the analysis demonstrated in this section, the following symbolic notation will be employed:

A > B > C (All 3 preferences - A over B, A over C and B over C - are significant at the .Ø5 level or better)

A ⩾ B > C (Only A over C and B over C hold at the .Ø5 level. The preference for A over B is present but does not appear with sufficient frequency to achieve the .Ø5 level)

A > B ⩾ C (A over B and A over C both hold at the .Ø5 level. B over C is a more frequent response than C over B, but not significantly so)

A ⩾ B ⩾ C* (Only A over C is significant)

A ⩾ B ⩾ C (None of the frequencies of preference between pairs reaches the .Ø5 level of significance)

It may happen that frequencies of preferences are exactly equal between alternatives, in which case the "=" sign will be used with its conventional meaning (e.g. A > B = C: A is significantly preferred to both B and C, but B and C are equally frequent responses).

(3) General preferences considering a total series of value-orientation items

The desire here is to consider a summary statement utilising all the items representing a particular value orientation. We wish to characterise groups, for purposes of analysis, as being, for example, dominantly oriented to Present time or Future time, regardless of the behaviour sphere sampled by the specific items.

Considering all the responses made by group members to all items testing a particular value orientation, and utilising three pairs of alternatives ([A, B], [A, C], [B, C]), we reason that if there is no general preference within each pair for one alternative over another, then a person should prefer A to B (or A to C, or B to C) for one-half of the items which he responds to in this value-orientation series, and for the other half he should prefer B to A (or C to A, or C to B). Thus, for example, when we consider the three pairs of the Man-Nature orientation alternatives for each individual, we compute three scores: (1) the number of times With is preferred to Over; (2) the number of times Subjugated is preferred to Over; (3) the number of times With is preferred to Subjugated. Since there are five items in each of the five value orientations, a single individual may receive a score from Ø (zero) to 5 (five) on each pair of alternatives. We have hypothesised that if no preference exists we would expect an equal distribution of preferences among each pair of alternatives in the orientation series, i.e. a score of 2.5 ($5 \div 2$). We can assess the difference between observed mean frequency of favourable responses and our expected mean frequency of favourable

responses (always 2.5), within each pair of alternatives, via T-Tests. The notation used to summarise the tendency towards consensus within groups for each value orientation will be that used in the previous section.

Harmony With $\geqslant$ Subjugation To $>$ Mastery Over would signify a non-significant preference for Harmony With over Subjugation To but significant preferences for Harmony With over Mastery Over, and Subjugation To over Mastery Over.

(4) Testing for Between Group Differences

Groups are placed on eleven dimensions to carry out this analysis. These dimensions involve two alternatives from the various value orientations. They are [Doing, Being], [Lin, Coll], [Lin, Ind], [Coll, Ind], [Past, Pres], [Past, Fut], [Pres, Fut], [Subj, With], [Subj, Over], [With, Over], [Pessimis, Optimis]. Each dimension runs from complete preference of position A over position B (say, Doing over Being), through equal preference for both (say, Doing equals Being), to complete preference of position B over position A (say, Being over Doing). Taking the mean values for sub-cultures on these dimensions (as computed in the previous section), and testing for between-culture variation of a significant magnitude by means of T-Test, gives us the answer to question 4.

7.5.2 Control Groups Compared

The results of the statistical analysis of the data are reported here using the four-step outline developed in the preceding section. Table 7.4 presents findings relating to within-group regularities on

Table 7.4. Significance of patterning of responses on individual items of the V.O.S., separately for each control group

Item	Question number	Significance of patterning H.R.A.	L.R.A.
R1	2	p<.01	p<.01
R2	9	n.s.	n.s.
R3	14	p<.01	p<.01
R4	16	n.s.	n.s.
R5	24	p<.01	p<.01
T1	4	p<.01	p<.01
T2	6	p<.01	p<.01
T3	13	p<.01	p<.01
T4	18	p<.01	p<.01
T5	22	p<.01	p<.01
MN1	5	p<.01	p<.01
MN2	7	p<.01	p<.01
MN3	11	n.s.	p<.05
MN4	17	p<.01	p<.01
MN5	20	p<.01	p<.01
A1	1	n.s.	n.s.
A2	10	n.s.	n.s.
A3	19	n.s.	n.s.
A4	21	p<.01	p<.05
A5	25	p<.01	p<.01
HN1	3	p<.01	p<.01
HN2	8	n.s.	n.s.
HN3	12	p<.01	p<.01
HN4	15	n.s.	p<.01
HN5	23	n.s.	n.s.

single items of the VOS. In the LRA control group all but seven items show a statistically signifcant tendency towards a non-random ordering of preferences. The exceptions are two items in the Relational series (R2 and R4), three items in the Activity Series (A1, A2 and A3) and two items in the Human Nature Series (HN2 and HN5). The HRA control group also fails to demonstrate any consensus over the ordering of these same items. In addition, one Man-Nature item (MN3) and a further Human Nature item (HN4) produce a pattern which might arise by chance.

Continuing with the analysis of single items, we now move ahead in our consideration of within-group regularity to consider the relative popularity of each of the particular alternatives which the members of each group were asked to rank-order. Table 7.5 presents the results of this analysis.

In order to complete the assessment of regularity of within-group responses, we need to go beyond individual item orderings and test for the signficance of the overall patterns of response to a total series of items. As described in the previous section, we compare observed frequencies of scores on each of eleven pairs of alternatives (or dimensions) with the expected null score (2.5). The results of this summary analysis for each control group are given in Table 7.6. The total orientation patterning within each group is given in Table 7.7. The HRA group demonstrates a significant preference for Collateral over both Individualistic and Lineal alternatives on the Relational orientation, but they do not prefer the Individualistic alternative significantly more than the Lineal alternative. On the Time orientation, the Present is preferred significantly more than Future, and the Future in turn is preferred

Table 7.5. Summary of Item by Item Analysis within each control group*

Item	Question	HRA	LRA
R1	2	Coll ≫ Ind > Lin	Ind > Coll > Lin
R2	9	Coll ≫ Lin ≫ Ind	Coll ≫ Ind = Lin
R3	14	Lin > Coll ≫ Ind	Lin > Coll ≫ Ind
R4	16	Coll ≫ Ind ≫ Lin	Ind ≫ Coll ≫ Lin
R5	24	Coll > Ind ≫ Lin	Coll > Ind > Lin
T1	4	Pres > Fut > Past	Pres > Fut > Past
T2	6	Fut ≫ Pres > Past	Fut ≫ Pres ≫ Past*
T3	13	Pres ≫ Fut > Past	Pres > Fut > Past
T4	18	Pres > Fut > Past	Pres > Fut > Past
T5	22	Pres > Fut ≫ Past	Pres ≫ Fut > Past
MN1	5	With ≫ Subj ≫ Over*	With ≫ Subj ≫ Over*
MN2	7	Subj = Over > With	Over > Subj ≫ With
MN3	11	With ≫ Over ≫ Subj	Over ≫ With ≫ Subj*
MN4	17	Over ≫ Subj ≫ With*	Over ≫ Subj > With
MN5	20	Subj ≫ Over > With	Subj ≫ Over > With
A1	1	Being ≫ Doing	Being ≫ Doing
A2	10	Being ≫ Doing	Being ≫ Doing
A3	19	Being ≫ Doing	Being ≫ Doing
A4	21	Doing > Being	Doing > Being
A5	25	Doing > Being	Doing > Being
HN1	3	Optimis > Pessimis	Optimis > Pessimis
HN2	8	Pessimis ≫ Optimis	Optimis ≫ Pessimis
HN3	12	Optimis > Pessimis	Optimis > Pessimis
HN4	15	Optimis ≫ Pessimis	Optimis > Pessimis
HN5	23	Optimis ≫ Pessimis	Pessimis ≫ Optimis

* See text for explanation of notation used

Table 7.6. Summary analysis of group preferences within specific paired alternatives, separately for HRA and LRA

Orientation/ Dimension	H.R.A. Observed* mean frequency	t**	p***	L.R.A. Observed* mean frequency	t**	p***
Relational						
Lin > Coll	1.82	- 5.05	p<.001	1.94	- 3.78	p<.001
Lin > Ind	2.36	- 1.03	n.s.	1.84	- 4.78	p<.001
Coll > Ind	3.34	5.84	p<.001	2.55	0.32	n.s.
Time						
Past > Pres	0.83	-12.94	p<.001	0.65	-13.79	p<.001
Past > Fut	1.32	- 8.72	p<.001	0.98	-10.59	p<.001
Pres > Fut	3.12	4.05	p<.001	3.36	5.69	p<.001
Man-Nature						
Subj > With	3.00	3.50	p<.01	3.11	3.94	p<.001
Subj > Over	2.54	0.25	n.s.	2.12	- 2.01	p<.05
With > Over	2.03	- 3.05	p<.01	1.60	- 5.98	p<.001
Activity						
Doing > Being	2.79	1.75	n.s.	2.74	1.28	n.s.
Human Nature						
Pessimis > Optimis	1.87	- 4.08	p<.001	1.45	- 8.36	p<.001

* The expected mean frequency is 2.5 throughout.
** The sign of t tells us the alternative which is the more popular; a plus sign means the first alternative listed in the first column is preferred, a minus sign that the second alternative is preferred.
*** All probabilities are two-tailed.

significantly more than the Past alternative. On the Man-Nature orientation, both the Subjected and Over positions are preferred significantly to the With position, but the preference for Subjected above Over does not reach significance. No significant pattern emerges on the Activity orientation. Finally, the Optimistic position is preferred significantly over the Pessimistic position on the Human Nature orientation.

In the LRA group, identical patterning is found on the Time, Activity and Human Nature orientations to that discovered in the HRA group. On the Relational orientation, the ordering of alternatives is similar but the significance of the preferences between alternatives differs somewhat. In the LRA the Collateral and Individualistic positions are preferred significantly more than the Lineal alternative, but the preference for the Collateral over the Individualistic alternative is not significantly different from chance. The Man-Nature orientation reveals the only case of a difference in ordering of preferences between the two groups. In the LRA, the Over position is ranked first (compared to the Subjected position in HRA) and is significantly preferred to the Subjected position, which in turn is significantly preferred to the With position.

The findings relating to the HRA group are generally in line with predictions with a few exceptions. In particular, the significant preference for the Optimistic position in the Human Nature orientation was not expected. Other exceptions are less pronounced and concern the failure to discover a significant patterning between alternatives, rather than a reversal order among alternatives. We are here referring to the non-significant preferences for Doing over Being (Activity orientation) and for Subjected above Over (Man-Nature

orientation).

The results reported in Table 7.7 for the LRA group are less in line with expectations than were the results for the HRA group. Major reversals of predictions are the failure to find a significant preference for the Individualistic alternative (Relational orientation), the Future alternative (Time orientation) and the Being alternative (Activity). The patterning of the Man-Nature and Human Nature orientations is as predicted.

However, we may be overstating the unexpectedness of the findings. The hypotheses relating to the VOS were actually couched more in terms of relative differences between groups (subcultures) on dimensions and orientations of the VOS, rather than in terms of absolutely different patterns within each group. Thus, if we take the Relational orientation as an example, it was hypothesised that the HRA would show a greater preference for the Collateral pole of the [Collateral, Individualistic] dimension than the LRA. Although ideal-typical patterning in the two groups might place HRA respondents in the Collateral half of the dimension and LRA respondents in the Individualistic half of the dimension, it was assumed that such a marked difference between groups would be most unlikely. In any case, it is almost certainly mistaken to look upon the mid-point of any of the dimensions as a clear dividing line between the two positions of the dimension. It is more appropriate to treat it as the approximate centre of a larger region where aspects of both poles of the dimension are present. A "real" mid-point does not exist and, if it did, it might well not be positioned exactly half way between the two extreme poles of the dimension.

Table 7.7. Total orientation patterning within each control group

Orientation	HRA	LRA
Relational	Coll > Ind ≫ Lin	Coll ≫ Ind > Lin
Time	Pres > Fut > Past	Pres > Fut > Past
Man-Nature	Subj ≫ Over > With	Over > Subj > With
Activity	Doing ≫ Being	Doing ≫ Being
Human Nature	Optimis > Pessimis	Optimis > Pessimis

For our purposes, the most important analysis concerns the significance of the relative positioning of the mean group scores on each of the eleven VOS dimensions. The results of this analysis are reported in Table 7.8. Significant differences were found on the [Lin, Ind], [Coll, Ind], [With, Over] and [Pessimis, Optimis] dimensions. These differences may be summarised as follows:

- Greater preference for the Individualistic over the Lineal alternative (Relational orientation) is shown in the LRA compared to the HRA
- Greater preference for the Collateral over the Individualistic alternative (Relational orientation) is shown in the HRA compared to the LRA
- Greater preference for the Over above the With alternative (Man-Nature orientation) is shown in the LRA compared to the HRA
- Greater preference for the Optimistic over the Pressimistic alternative (Human Nature orientation) is shown in the LRA compared to the HRA

Two further differences are of borderline significance (.10 < p > .05). Since the findings are in the expected direction and a two-tailed test of significance is being used, these differences should not be overlooked.

- Greater preference for the Future over the Past alternative (Time orientation) is shown in the LRA compared to the HRA
- Greater preference for the Over above the Subjected alternative (Man-Nature orientation) is shown in the LRA than in the HRA.

We have seen that on six of the eleven dimensions there are significant (or borderline significant) differences between HRA and LRA control groups. All these differences are in the predicted direction. Of the five non-significant findings, only two are particularly noteworthy: those relating to the [Doing, Being] and [Present, Future] dimensions. Neither control group expressed a

Table 7.8. Significance of Differences in Group Mean Scores* on Eleven Dimensions of the V.O.S.: LRA + HRA Controls Compared

Dimension	t**	p***
Lin, Coll	0.60	.550
Lin, Ind	-2.68	.009
Coll, Ind	-3.71	.000
Past, Pres	-0.97	.336
Past, Fut	-1.72	.088
Pres, Fut	1.12	.267
Subj, With	0.52	.603
Subj, Over	-1.69	.095
With, Over	-2.00	.049
Doing, Being	-0.20	.839
Pessimis, Optimis	-2.11	.037

* Mean scores are given in Table 7.6
** df = 98 throughout. Positive score signifies a "higher" total in LRA.
*** All probabilities are two-tailed.

clear preference in the Activity orientation, and both groups were firmly placed in the Present half of the [Present, Future] dimension.

The analyses above relating to within-group and between-group preferences on paired alternatives (Tables 7.6 and 7.8) were based on the five-item VOS as it was originally administered. However, we pointed out in Chapter 6 that there is empirical evidence to suggest that each value orientation contains one item which generates an unexpectedly large number of inconsistent responses. These items are Item 5 in the Activity orientation (Q25), Item 3 in the Relational orientation (Q14), Item 2 in the Time orientation (Q6), Item 1 in the Man-Nature orientation (Q5) and Item 2 in the Human Nature orientation (Q8). A re-analysis of within-group and between-group preferences on paired alternatives was therefore undertaken, using the remaining four items in each value orientation.

Table 7.9 reports the significance of patterns of response within each group for all eleven paired alternatives. The results of this four-item analysis should be compared with the original findings given in Table 7.6. The only major difference in the HRA is that the non-significant preference Ind $\geqslant$ Lin is now highly significant (Ind > Lin). In the LRA, the preference Coll $\geqslant$ Ind is now highly significant (Coll > Ind), while the significant preference Over > Subj is no longer significant (Over $\geqslant$ Subj). In both groups the non-significant preference Doing $\geqslant$ Being has been changed to the non-significant preference Being $\geqslant$ Doing. Table 7.10 summarises the total orientation patterning within each control group, based on the four-item version of the VOS, and should be compared with the original patterning in Table 7.7.

Table 7.9. Summary analysis of group preferences within specific paired alternatives, separately for HRA and LRA - 4 item V.O.S.

Orientation/ Dimension	H.R.A. Observed* mean frequency	H.R.A. t**	H.R.A. p***	L.R.A. Observed* mean frequency	L.R.A. t**	L.R.A. p***
Relational						
Lin > Coll	1.22	- 6.30	<.001	1.04	- 8.16	<.001
Lin > Ind	1.36	- 4.55	<.001	1.13	- 4.97	<.001
Coll > Ind	2.47	2.93	<.01	2.32	2.36	<.05
Time						
Past > Pres	0.63	-11.82	<.001	0.41	-14.41	<.001
Past > Fut	1.05	- 6.96	<.001	0.79	- 9.77	<.001
Pres > Fut	2.65	4.24	<.001	2.50	3.99	<.001
Man-Nature						
Subj > With	2.64	3.96	<.001	2.61	4.99	<.001
Subj > Over	2.18	1.14	n.s.	1.89	- 0.79	n.s.
With > Over	1.62	- 2.76	<.01	1.14	- 5.18	<.001
Activity						
Doing > Being	1.87	- 0.73	n.s.	1.96	- 0.23	n.s.
Human Nature						
Pessimis > Optimis	1.13	- 6.82	<.001	1.01	- 8.14	<.001

* The expected mean frequency is 2.0 throughout.
** The sign of t tells us the alternative which is the more popular; a plus sign means the first alternative listed in the first column is preferred, a minus sign that the second alternative is preferred.
*** All probabilities are two-tailed.

Table 7.10. Total orientation patterning within each control group - 4 item V.O.S.

Orientation	HRA	LRA
Relational	Coll > Ind > Lin	Coll > Ind > Lin
Time	Pres > Fut > Past	Pres > Fut > Past
Man-Nature	Subj ≫ Over > With	Over ≫ Subj > With
Activity	Being ≫ Doing	Being ≫ Doing
Human Nature	Optimis > Pessimis	Optimis > Pessimis

Finally, we have to examine the significance of between-subculture differences on mean scores for each dimension, using the four-item version of the VOS. Table 7.11 presents the main findings. Comparison with the original findings (Table 7.8) reveals that the greater preference for the Present over the Past alternative (Time orientation) in the LRA is now of borderline significance ($p = .\emptyset73$) ($p > .3$ for the five-item analysis); the greater preference for the Over rather than the Subjected alternative (Man-Nature orientation) in the LRA, previously of borderline significance ($p = .\emptyset95$), is now highly significant; and the preference for the Optimistic over the Pessimistic alternative (Human Nature orientation), significant in the original analysis ($p = .\emptyset37$), is now no greater than chance. In both analyses no significant between-group differences were found on the [Lin, Coll], [Pres, Fut], [Subj, With], [Doing, Being] dimensions. Significant differences between groups in both analyses were found on the [Lin, Ind], [Coll, Ind] and [With, Over] and [Past, Fut] dimensions. Of the three discrepancies in significance levels between the two analyses, only the finding relating to the [Pessimis, Optimis] dimension is of major consequence. It has to be borne in mind that the evidence of a greater preference for a more optimistic conception of human nature in the LRA is less firm than the evidence concerning the other dimensions.

7.6 Ways of Behaving Instrument: findings

7.6.1 Control groups compared

A restricted attempt to compare and contrast normative aspects of the subcultures of the two area-types was made using the Ways of Behaving Instrument. Tables 7.12 and 7.13 present data on the eval-

Table 7.11. Significance of Differences in Group Mean Scores* on Eleven Dimensions of the V.O.S.: LRA + HRA Controls Compared - 4 item V.O.S.

Dimension	t**	p***
Lin, Coll	1.15	.254
Lin, Ind	-2.53	.013
Coll, Ind	-4.08	.000
Past, Pres	-1.81	.073
Past, Fut	-1.70	.093
Pres, Fut	1.37	.174
Subj, With	0.61	.544
Subj, Over	-2.27	.026
With, Over	-2.45	.016
Doing, Being	0.04	.966
Pessimis, Optimis	-1.22	.225

* Mean scores are given in Table 7.9
** df = 98 throughout. Positive score signifies a "higher" total in LRA
*** All probabilities are two-tailed.

Table 7.12. Ways of Behaving Instrument: Mean scores (and S.D.) on each EVALUATION item: Control groups compared

Item	HRA		LRA		T-value	2-tail probability
	Mean	(S.D.)	Mean	(S.D.)		
WOB1 - Put aside money	15.58	(15.60)	23.60	(17.21)	2.44	.016
WOB2 - Child leave school*	37.72	(29.45)	60.20	(21.38)	4.35	.000
WOB3 - Quarrel and row*	45.44	(26.37)	52.40	(18.53)	1.50	.138
WOB4 - Sex before marriage*	52.15	(27.71)	52.86	(20.59)	0.14	.886
WOB5 - Confide problems*	46.82	(26.63)	45.38	(20.16)	-0.30	.763
WOB6 - Commit suicide	83.58	(18.98)	81.53	(19.53)	-0.52	.601
WOB7 - Go out to work	46.78	(28.06)	62.40	(25.37)	2.87	.005
WOB8 - Fights in street*	74.92	(24.03)	86.20	(15.73)	2.78	.007
WOB9 - Beat children*	79.73	(28.05)	89.16	(18.16)	1.97	.053
WOB10 - Vote in election	20.54	(19.75)	16.42	(17.36)	-1.10	.275
WOB11 - Get divorce	43.65	(26.77)	40.64	(21.07)	-0.61	.542
WOB12 - Take car for joy ride*	81.92	(21.23)	86.78	(15.23)	1.30	.197
WOB13 - Argue with fists*	79.61	(23.92)	89.50	(13.41)	2.53	.014
WOB14 - Get pills*	50.25	(29.40)	60.12	(21.16)	1.90	.061
WOB15 - Share worries*	40.86	(30.51)	21.12	(19.18)	-3.84	.000
WOB16 - Deliberate self-harm	89.32	(15.40)	84.94	(17.11)	-1.32	.191
WOB17 - Help round house	24.78	(21.86)	22.00	(18.46)	-0.68	.499
WOB18 - Get drunk	59.58	(23.47)	71.02	(20.78)	2.58	.011
WOB19 - Batter wife	85.91	(21.01)	90.28	(17.01)	1.12	.266

* For all items marked thus a separate variance estimate is used to calculate an approximation to t, since the F test of sample variances is significant ($p < .10$, 2-tail test).

Table 7.13. Ways of Behaving Instrument: Mean scores (and S.D.) on each EXPECTATION item: Control groups compared

Item	HRA Mean	HRA (S.D.)	LRA Mean	LRA (S.D.)	T-value	2-tail probability
WOB101 - Put aside money*	44.14	(31.00)	30.22	(23.55)	-2.51	.014
WOB102 - Child leave school*	17.06	(18.49)	52.40	(28.97)	7.16	.000
WOB103 - Quarrel and row	26.39	(24.65)	41.21	(24.56)	2.95	.004
WOB104 - Sex before marriage	20.24	(22.30)	33.71	(23.29)	2.82	.006
WOB105 - Confide problems	38.71	(28.32)	42.67	(24.73)	0.72	.472
WOB106 - Commit suicide*	72.36	(29.95)	81.90	(20.09)	1.75	.084
WOB107 - Go out to work	28.19	(24.31)	45.65	(30.51)	3.10	.003
WOB108 - Fights in street*	51.78	(33.15)	84.43	(16.39)	6.23	.000
WOB109 - Beat children*	73.63	(27.26)	84.80	(21.44)	2.25	.027
WOB110 - Vote in election*	29.88	(29.63)	20.94	(17.10)	-1.82	.073
WOB111 - Get divorce	30.96	(27.25)	37.32	(28.36)	1.10	.276
WOB112 - Take car for joy ride*	40.39	(30.65)	79.38	(21.25)	7.27	.000
WOB113 - Argue with fists*	56.41	(32.51)	83.38	(20.19)	4.95	.000
WOB114 - Get pills	26.61	(23.87)	38.82	(26.50)	2.31	.023
WOB115 - Share worries	41.70	(26.95)	29.92	(23.17)	-2.30	.024
WOB116 - Deliberate self-harm*	63.66	(32.90)	84.79	(17.80)	3.77	.000
WOB117 - Help round house	42.24	(32.34)	33.66	(26.84)	-1.41	.161
WOB118 - Get drunk	33.12	(27.17)	55.54	(29.32)	3.97	.000
WOB119 - Batter wife*	64.09	(32.22)	82.90	(19.48)	3.41	.001

* For all items marked thus a separate variance estimate is used to calculate an approximation to t, since the F test of sample variances is significant ($p < .10$, 2-tail test).

uation and expectation sections, respectively, of the WOBI. A higher score on an evaluation item means that the behaviour is considered to be more deviant ("should not"), while a lower score suggests that it is more normative ("should"). Expectation items are scored from very likely (zero) to very unlikely (100). Thus, a higher score signifies a greater tendency to rate the behaviour more unlikely. Only key words are provided in the Tables to denote the item. For a full description, see Appendix 6.5.

A summary analysis of group mean scores relating to individual Evaluation items is provided in Table 7.12. Significant ($p<.05$) differences were found on seven items: WOB1, WOB2, WOB7, WOB8, WOB13, WOB15, WOB18. Differences of borderline significance ($.10 < p > .05$) were found on two items: WOB9 and WOB14. These findings can be stated in full, thus:

WOB1 - The belief that the average married couple should put aside money for future needs is significantly stronger in the HRA than in the LRA

WOB2 - The belief that the average child should not leave school at 16 is significantly stronger in the LRA than in the HRA

WOB7 - The belief that the average married woman with children should not go out to work is significantly stronger in the LRA than in the HRA

WOB8 - The belief that the average man should not get into fights in the street is significantly stronger in the LRA than in the HRA

WOB9 - The belief that average parents should not severely beat their children is stronger in the LRA than in the HRA

WOB13 - The belief that the average adult should not settle an argument with fists is significantly stronger in the LRA

than in the HRA

WOB14 - The belief that a person should not get pills from the doctor when feeling nervy/depressed is stronger in the LRA than in the HRA

WOB15 - The belief that the average couple should share problems is significantly stronger in the LRA than in the HRA

WOB18 - The belief that the average man should not get drunk when going out with friends is significantly stronger in the LRA than in the HRA

The findings of significant (or borderline significant) differences on nine items may give a somewhat misleading impression if not considered more closely. Firstly, we should note that the two groups could not be distinguished in terms of their responses to a further ten items. Secondly, even a cursory inspection of Table 7.12 suggests that the two area populations are inhabiting essentially the same normative world: the differences are of degree rather than of kind. Perhaps this can be seen more clearly if we examine the distribution of reponses in each group for each item. Table 7.14 presents this information. Every respondent is allotted to one of six categories, depending upon their rating on the 100 mm analogue line (or if they have ticked the "Not Sure" response): 0-15 mm (should - extreme); 16-45 mm (should - moderate); 46-55 mm (may/may not); 56-85 mm (should not - moderate); 86-100 mm (should not - extreme); not known. In general, there is a considerable degree of overlap in the distribution of responses between groups (except on items 2, 15 and 18). Using the information provided in the Table, and adopting a number of arbitrary but defensible ground rules, we can allocate each item to the category "normative", "deviant", "normative/permitted", "deviant/permitted" and "no consensus". An

Table 7.14. Distribution of responses for individual Evaluation items of the WOBI - Control groups compared

Item	HRA						LRA					
	0-15 mm	16-45 mm	46-55 mm	56-85 mm	86-100 mm	Not Sure	0-15 mm	16-45 mm	46-55 mm	56-85 mm	86-100 mm	Not Sure
WOB1	30	15	5	0	0	0	18	22	10	0	0	0
WOB2	13	16	11	5	5	0	1	5	22	14	7	1
WOB3	6	16	15	4	7	2	1	11	19	14	3	2
WOB4	6	9	20	3	10	2	2	9	25	9	5	0
WOB5	6	15	16	5	7	1	3	25	13	5	4	0
WOB6	0	0	9	7	32	2	0	0	10	10	29	1
WOB7	6	16	16	3	8	1	2	7	14	12	13	2
WOB8	2	1	10	13	24	0	0	0	4	13	33	0
WOB9	2	6	2	6	32	2	1	1	2	5	41	0
WOB10	26	10	12	0	0	2	31	12	7	0	0	0
WOB11	10	10	19	4	6	1	11	7	24	4	1	3
WOB12	0	2	6	10	31	1	0	1	3	13	32	1
WOB13	1	3	6	11	28	1	0	1	1	11	37	0
WOB14	8	11	13	7	9	2	1	7	21	13	8	0
WOB15	14	7	18	5	5	1	24	16	10	0	0	0
WOB16	0	0	5	6	36	3	0	1	5	13	30	1
WOB17	21	15	11	1	1	1	22	17	10	0	0	1
WOB18	2	8	19	10	11	0	0	3	12	18	17	0
WOB19	1	0	6	4	34	5	1	0	2	6	41	0

item was labelled "normative" if ≥35 members of the group scored Ø-45 on the evaluative scale and ≤8 members socred 56-1ØØ. An item was "deviant" if ≥35 members scored 56-1ØØ and ≤8 members scored Ø-45 on the scale. An item was "normative/permitted" if ≤11 members of the group scored 56-1ØØ, and "normative/deviant" if ≤11 members scored Ø-45 on the scale. All other patterns of within-group responses were considered to indicate "no consensus". Table 7.15 shows the allocation of items to these categories. In both groups, items 1, 1Ø and 17 were considered "normative", items 6, 8, 9, 12, 13, 16 and 19 "deviant" and items 3 and 4 "no consensus". Only six items were not allocated to the same category in both groups: item 2 ("deviant/ permitted" in LRA, "normative/ permitted" in HRA); item 5 ("normative/permitted" and "no consensus", respectively); item 7 ("deviant/permitted" and "normative/permitted", respectively); item 14 ("deviant/permitted" and "no consensus", respectively); item 15 ("normative" and "normative/permitted", respectively); and item 18 ("deviant" and "deviant/permitted", respectively). These discrepancies are not marked: in no case is an item overwhelmingly "deviant" in one area and "normative" in another. Some items which generate significantly different mean scores in the two groups are still to be found in the same category in both groups - e.g. items 1, 8, 9 and 13.

One further point of interest can be made from analysis of Tables 7.14 and 7.15 - namely, that the hypothesised tendency for HRA controls to rate more permissively (may/may not) is not found. In both groups, five items are placed in the "normative/permitted" or "deviant/permitted" categories (Table 7.15). Seven items generate more responses in the 46-55 (may/may not) category in the LRA than in the HRA, while 1Ø items generate more such responses in the HRA than

Table 7.15. Categorisation of WOBI Evaluation Items: Control Groups Compared

Item	HRA	LRA
WOB1	Normative	Normative
2	Normative/Permitted	Deviant/Permitted
3	No consensus	No consensus
4	No consensus	No consensus
5	No consensus	Normative/Permitted
6	Deviant	Deviant
7	Normative/Permitted	Deviant/Permitted
8	Deviant	Deviant
9	Deviant	Deviant
10	Normative	Normative
11	Normative/Permitted	Normative/Permitted
12	Deviant	Deviant
13	Deviant	Deviant
14	No consensus	Deviant/Permitted
15	Normative/Permitted	Normative
16	Deviant	Deviant
17	Normative	Normative
18	Deviant/Permitted	Deviant
19	Deviant	Deviant

Normative : $\geqslant$ 35 scoring 0-45
$\leqslant$ 8 scoring 56-100

Deviant : $\geqslant$ 35 scoring 56-100
$\leqslant$ 8 scoring 0-45

Normative/Permitted : $\leqslant$ 11 scoring 56-100

Deviant/Permitted : $\leqslant$ 11 scoring 0-45

No Consensus : - None of the above categories

in the LRA (see Table 7.14); this difference is not significant. Over all nineteen items, the median number of responses in the may/may not category (46-55) is 10 in the LRA and 11 in the HRA (see Table 7.14).

Another hypothesis related to the amount of consensus in the two areas. Table 7.15 suggests that, contrary to expectations, there may have been less consensus in the HRA. This impression is supported when reference is made once again to Table 7.12. On 16 of the 19 items the standard deviation is greater in the HRA than in the LRA. (The exceptions are item 1 and, interestingly, the two items relating to suicide and parasuicide, items 6 and 16.) On ten of these items (marked by an asterisk in Table 7.12) the standard deviations are significantly different. In part this is not surprising since the mean scores in the HRA tend to be nearer the extremes of zero or 100 and therefore restrict the possible size of the standard deviation in comparison with the HRA. On four items (3, 4, 5 and 12), the mean scores are not significantly different, yet the F value for the difference in standard deviations reaches significance.

The preceding analysis suggests that the HRA and LRA control groups share a broadly similar view of what constitutes normative and deviant behaviour. Overall, there is no support whatsoever for the contention that the HRA constitutes an oppositional culture or contraculture in comparison with the dominant culture of the LRA. Nevertheless, we should note evidence which confirms the predicted tendency for the HRA subculture to be less severe in the proscription of deviant behaviour. On items 6 and 16, which are of particular interest here, no differences were found. However, when all items are ranked in order from most deviant to least deviant (whether on

the basis of mean scores or number of respondents scoring in the extreme category, 86-100), some interesting differences do emerge. In the LRA the item which is considered to be most deviant (based on the overall mean score) is wife-battering (19), followed by settling arguments with fists (13), beating children (9), taking car for joyride (12), getting into fights in the street (8) and parasuicide (16). The order in the HRA is parasuicide, followed by wife-battering, suicide (6), taking car for joyride, beating children and settling arguments with fists. Thus, in the HRA parasuicide is rated most deviant, but only sixth most deviant in the LRA; suicide is the third most deviant behaviour in the HRA, but only seventh most deviant in the LRA. Additionally, two of the three items which generate more consensus in the HRA are those relating to suicide and parasuicide. These findings suggest that parasuicide may be a specially disvalued behaviour in the HRA, generating a particularly high level of shared disapproval throughout the subculture.

A summary analysis of group mean scores relating to individual Expectation items is provided in Table 7.13. Significant ($p<.05$) differences were found on items WOB101, WOB102, WOB103, WOB104, WOB107, WOB108, WOB109, WOB112, WOB113, WOB114, WOB115, WOB116, WOB118 and WOB119. Differences of borderline significance ($.10 < p > .05$) were found on items WOB106 and WOB110. All differences were in the expected direction. We should pay particular attention to the fact that normative behaviours (items 1 and 10) are reported to be more likely to occur in the LRA than in the HRA, and deviant behaviour (items 6, 8, 9, 12, 13, 16 and 19) more likely to occur in the HRA than in the LRA. It will also be apparent that the differences in normative expectations between the groups are far more pronounced than those found on the evaluation items. A difference of

more than 15 points between the mean scores of groups was found on only four evaluation items. The same difference was found on eight expectation items. Table 7.16 allocates scores to three discrete categories: likely (0-45); neither likely nor unlikely (45-55); and unlikely (56-100). (There is also the "not sure" category.) Comparison of the two area-groups supports the conclusion that differences are far more pronounced in relation to this particular aspect of the normative system. Nevertheless, once again it is important to guard against any exaggeration of what these quantitative differences actually signify. Adopting another set of arbitrary but commonsensical rules, each expectation item can be allocated to three categories: "likely", if $\geqslant$33 members of a group score in the range 0-55; "not likely", if $\geqslant$35 score in the range 46-100; and "no consensus" for any other pattern. Table 7.17 presents the results of this analysis, which reveals that in both areas there was a tendency to believe that the following behavioural items were likely to occur: items 101, 104, 105, 110, 111, 114, 115, 117; and that items 106, 109 and 119 were unlikely to occur. Eight items were placed in different categories, but only on item 112 were the majority of group members holding diametrically opposed views. On items 102, 103, 107 and 118, there was no consensus in the LRA and a tendency to rate the behaviour "likely" in the HRA; and on items 108, 113 and 116, there was no consensus in the HRA and a tendency to rate the behaviour "not likely" in the LRA.

The question of differential level of consensus in the two groups cannot be resolved by reference to Table 7.17 alone. However, if we return to Table 7.13, we find that on thirteen of the nineteen items the standard deviation is higher in the HRA than in the LRA (the exceptions are items 102, 104, 107, 111, 114 and 118). On nine

Table 7.16. Distribution of responses for individual Expectation items of the WOBI - Control groups compared

Item	HRA				LRA			
	0-45mm	46-55mm	56-100mm	Not Sure	0-45mm	46-55mm	56-100mm	Not Sure
WOB101	33	0	16	1	39	3	8	0
WOB102	45	2	3	0	20	5	23	2
WOB103	38	6	5	1	27	5	15	3
WOB104	42	0	4	4	32	6	7	5
WOB105	32	4	12	2	28	6	12	4
WOB106	7	2	33	8	6	0	43	1
WOB107	39	1	8	2	23	5	20	2
WOB108	23	3	24	0	1	4	44	1
WOB109	8	0	40	2	3	1	46	0
WOB110	37	3	8	2	44	3	3	0
WOB111	36	2	10	2	28	5	11	6
WOB112	29	4	16	1	5	1	41	3
WOB113	18	4	27	1	2	2	46	0
WOB114	37	3	6	4	28	5	12	5
WOB115	30	3	14	3	39	4	6	1
WOB116	13	1	30	6	2	1	44	3
WOB117	31	2	16	1	33	5	9	3
WOB118	37	4	9	0	19	9	22	0
WOB119	12	1	33	4	3	0	45	2

Table 7.17. Categorisation of WOBI Expectation Items: Control Groups Compared

Item	HRA	LRA
WOB101	Likely	Likely
2	Likely	No consensus
3	Likely	No consensus
4	Likely	Likely
5	Likely	Likely
6	Not likely	Not likely
7	Likely	No consensus
8	No consensus	Not likely
9	Not likely	Not likely
10	Likely	Likely
11	Likely	Likely
12	Likely	Not likely
13	No consensus	Not likely
14	Likely	Likely
15	Likely	Likely
16	No consensus	Not likely
17	Likely	Likely
18	Likely	No consensus
19	Not likely	Not likely

Likely : $\geqslant$ 33 scoring 0-55

Not likely : $\geqslant$ 35 scoring 46-100

No Consensus : Neither of the above categories

of these items (marked by an asterisk in Table 7.13) the standard deviations are significantly different. (There is also a significant difference on a tenth item, WOBlØ2, this being the sole case where the standard deviation is higher in the LRA.) However, in every case the mean group scores are also significantly different and the standard deviation is higher in the group with the less extreme mean score. On the basis of this analysis and the data presented in Tables 7.15 and 7.16, we must conclude that the null hypothesis of no difference in levels of consensus on expectation items between area groups has not been refuted.

7.6.2 A serendipitous finding

Prior to the interview phase of the study no formal hypothesis had been proposed concerning the likely relationship between evaluation and expectation at the item level, and differences in such a relationship across areas. However, during the course of fieldwork, I received the impression that, as far as LRA respondents were concerned, those behaviours which the local community tended to rate as deviant were also considered to be unlikely to be performed, while more normative (prescribed) behaviours were considered to be more likely. In other words, there appeared to be a fit or congruence between the evaluation and expectation of individual items of behaviour: people did what they were supposed to do, and refrained from doing what was forbidden. In the HRA, on the other hand, "deviant" behaviours were somewhat less severely proscribed but felt to be more commonly performed: the fit between evaluation and expectation was considerably more problematic. At the analysis phase of the research, I decided to test this impression statistically. I believed that this (possibly) greater discrepancy between evaluation

and expectation in the HRA could have some relevance to the understanding of the subculture of parasuicide. My first post hoc conceptualisation of the differential discrepancy was that it was a measure of social disorganisation, in the sense that Cavan (1928: 330) defines it: "the loss of control of mores over the members of the group". Subsequently, it occurred to me that these data might also (or alternatively) be seen as empirical support for the existence of normative "stretch" in the HRA. I return to discuss the significance of the findings in Chapter 9. For the present I will refer merely to the "absolute discrepancy score" on each of the nineteen items of the WOBI.

Operationally, the absolute discrepancy score is defined as the absolute difference between scores on the Evaluation and Expectation items which relate to the same behaviour. Thus, a particular individual may score 17 on item 1 (representing a fairly strong view that the average young married couple should put aside money) and 20 on item 101 (representing a fairly strong view that this form of behaviour is highly likely). The absolute difference of these two scores is 3. The lowness of the score signifies little discrepancy between the evaluation of the behaviour and the expectation of its occurrence. The greater the absolute difference score, the greater the discrepancy between evaluation and expectation. The theoretical range for scores on this discrepancy scale is 0-100. A mean discrepancy score for each group on each item can then be calculated. Table 7.18 presents the relevant data. On every item the mean discrepancy is higher in the HRA. The lowest mean discrepancy in the HRA is 22.44 (item 6 - suicide), yet thirteen of the nineteen items in the LRA have lower scores than this. The highest score in the LRA is 28.98 (item 14 - pills from doctor)

Table 7.18 Absolute discrepancy score on individual items of the WOBI - control groups compared

Item	HRA		LRA		Significance of difference (Mann-Whitney U Test - 2-tail probability)
	Mean Score	(S.D.)	Mean Score	(S.D.)	
1	35.06	(31.91)	20.06	(19.21)	.046
2	26.98	(25.97)	24.06	(19.65)	.989
3	29.83	(27.69)	17.87	(15.59)	.053
4	32.44	(26.96)	20.76	(20.02)	.049
5	28.13	(25.41)	20.46	(16.37)	.238
6	22.44	(26.03)	17.04	(16.72)	.545
7	30.64	(21.97)	24.89	(23.38)	.087
8	32.70	(29.60)	10.20	(14.25)	.000
9	24.70	(29.03)	9.88	(13.28)	.002
10	22.59	(25.89)	17.56	(14.59)	.837
11	32.09	(24.57)	25.79	(19.56)	.277
12	43.69	(29.12)	16.98	(16.91)	.000
13	29.78	(29.99)	11.32	(14.81)	.000
14	30.29	(26.11)	28.98	(24.69)	.994
15	27.83	(23.83)	20.20	(19.29)	.170
16	27.07	(30.57)	13.91	(14.07)	.062
17	30.12	(29.99)	24.89	(23.55)	.778
18	30.34	(24.90)	26.28	(25.03)	.252
19	32.16	(30.94)	11.98	(15.54)	.000

but twelve of the nineteen items in the HRA have higher scores than this. Since standard deviations are so markedly different between the groups across most items, the significance of differences in mean discrepancy scores between groups was tested by the nonparametric Mann-Whitney test throughout. Table 7.18 shows that the tendency to have a higher discrepancy score in the HRA was significant on items 1, 4, 8, 9, 12, 13 and 19; and of borderline significance on items 3, 7 and 16.

7.7 Case Vignette Instrument: findings

Hypotheses relating to the evaluation of parasuicide in the two control groups were measured by means of the Case Vignette Instrument. Table 7.19 presents mean group scores on each item of each vignette. In addition overall mean scores per vignette across both areas, and overall means per area across all vignettes, are provided.

For analytical purposes it was intended to examine differences between groups and between items across all vignettes. In order to provide some theoretical foundation for this approach, the correlation matrix of mean scores (N = 100) for all 36 items was subjected to a factor analysis. Using the principal factoring with iteration method and a varimax rotation, eleven factors emerged accounting for 73% of the variance. Table 7.20 shows the items which loaded >.4 on each factor. All vignettes relating to item 7 load on one factor; likewise, for items 8, 2, 6, 4 and 3. Item 1 loads on two factors. Only items 5 and 9 load highly on the same factor, and item Mary 5 does not load on any factor. Undoubtedly, the very high inter-correlation of items 5 and 9 causes this disruption of the general

Table 7.19. Case Vignettes: Mean scores, by item: Control groups compared

	MEAN SCORES				
	"MARY"	"FRANK"	"JOE"	"JANE"	OVERALL MEAN
Item 1					
LRA	2.94	2.82	3.06	3.26	3.02
HRA	3.62	3.16	3.40	3.46	3.41
OVERALL MEAN	3.28 *	2.99	3.23	3.36	3.22
Item 2					
LRA	4.44	4.50	4.06	4.12	4.28
HRA	4.14	3.96	3.74	3.92	3.94
OVERALL MEAN	4.29 (*)	4.23 *	3.90	4.02	4.11
Item 3					
LRA	4.24	4.12	4.04	4.24	4.16
HRA	4.16	3.80	3.90	4.16	4.01
OVERALL MEAN	4.20	3.96 (*)	3.97	4.20	4.08
Item 4					
LRA	2.94	3.18	3.26	3.46	3.21
HRA	3.00	2.68	3.14	2.98	2.95
OVERALL MEAN	2.97	2.93 *	3.20	3.22 *	3.08
Item 5					
LRA	4.12	2.62	3.82	3.80	3.59
HRA	3.58	2.78	3.42	3.44	3.31
OVERALL MEAN	3.85 *	2.70	3.62	3.62	3.45
Item 6					
LRA	3.20	3.30	3.46	3.34	3.33
HRA	3.08	3.26	3.46	3.42	3.31
OVERALL MEAN	3.14	3.28	3.46	3.38	3.32
Item 7					
LRA	2.68	2.88	2.66	2.82	2.76
HRA	2.50	2.26	2.30	2.40	2.37
OVERALL MEAN	2.59	2.57 *	2.48	2.61 (*)	2.56
Item 8					
LRA	3.32	3.12	2.96	3.42	3.21
HRA	3.60	3.32	3.38	3.40	3.43
OVERALL MEAN	3.46	3.22	3.17 (*)	3.41	3.32
Item 9					
LRA	3.94	2.54	3.82	3.74	3.51
HRA	3.24	2.54	3.20	3.24	3.06
OVERALL MEAN	3.59 *	2.54	3.51 *	3.49 (*)	3.28

* On items marked thus there was a significant ($p<.05$, t-test, 2-tailed) difference in mean scores between areas.

(*) Signifies $.10<p>.05$.

Table 7.20. Case Vignettes: Principal factoring with Iteration, Varimax Rotation

Factor	Items loading ⩾ .4
1	Mary 7, Frank 7, Joe 7, Jane 7
2	Mary 8, Frank 8, Joe 8, Jane 8
3	Mary 2, Frank 2, Joe 2, Jane 2
4	Joe 5, Joe 9
5	Mary 6, Frank 6, Joe 6, Jane 6
6	Jane 5, Jane 9
7	Mary 4, Frank 4, Joe 4, Jane 4
8	Frank 5, Frank 9
9	Mary 3, Frank 3, Joe 3, Jane 3
10	Frank 1, Joe 1, Jane 1
11	Mary 1

pattern of independence of items across factors (Mary 5 and 9 are correlated .59; Frank 5 and 9, .76; Joe 5 and 9, .79; Jane 5 and 9, .78: all Pearson correlations, 2 tailed, $p<.001$). When all item 9s are omitted, then no items within the same vignette load on the same factor. These findings lend support to the hypothesis that items are distinct and tap different aspects of the situation. Our intention to analyse inter-group differences on each item across vignettes does not violate the empirical structure of the data.

The results of the two-way analysis of variance (control group x vignette) on each item is shown in Table 7.21. There were significant differences in the rating of vignettes on items 1, 2, 3, 4, 5 and 9. The null hypothesis of no distinction between vignettes and responses to vignettes is therefore refuted, and support is given to the alternative hypothesis. On those items showing significant differences overall in the patterning of responses per vignette, the Duncan Multiple Range Test was applied to pinpoint significant inter-item differences. Table 7.22 reports the results of this analysis. Interpeting this Table, we can reach the following conclusions:

Item 1: Jane's action is seen as less understandable than Frank's.

Item 2: Both Frank and Mary are considered to be less deserving of punishment than Joe.

Item 3: Frank's action was more "right" than both Mary's and Jane's. Joe's action was more "right" than both Mary's and Jane's.

Item 4: Both Joe and Jane could have helped doing what they did to a significantly greater degree than Frank.

Item 5: Frank really wanted to die more than either Mary or Joe or Jane.

Item 9: Frank was trying to commit suicide to a significantly greater degree than Mary or Joe or Jane.

Table 7.21. Case Vignettes: 2 way analysis of variance (Vignettes, Control groups)

Item	Main effect - Groups	Main effect - Vignettes	Interaction Groups x Vignettes
1	F = 5.61 df = 1,98 p<.05	F = 2.60 df = 3,294 p=.05	F = 1.07 df = 3,294 n.s.
2	F = 5.51 df = 1,98 p<.05	F = 6.44 df = 3,294 p<.001	F = 1.00 df = 3,294 n.s.
3	F = 1.37 df = 1,98 n.s.	F = 4.07 df = 3,294 p<.01	F = 0.71 df = 3,294 n.s.
4	F = 2.10 df = 1,98 n.s.	F = 2.87 df = 3,294 p<.05	F = 2.39 df = 3,294 n.s.
5	F = 3.38 df = 1,98 n.s.	F =23.37 df = 3,294 p<.001	F = 2.11 df = 3,294 n.s.
6	F = 0.01 df = 1,98 n.s.	F = 2.57 df = 3,294 n.s.	F = 0.23 df = 3,294 n.s.
7	F = 4.00 df = 1,98 p<.05	F = 0.57 df = 3,294 n.s.	F = 1.41 df = 3,294 n.s.
8	F = 1.28 df = 1,98 n.s.	F = 2.50 df = 3,294 n.s.	F = 1.06 df = 3,294 n.s.
9	F = 6.93 df = 1,98 p <.01	F =22.66 df = 3,294 p<.001	F = 2.27 df = 3,294 n.s.

Table 7.22. Case Vignettes: Significance of inter-item differences on Case Vignette Instrument - Control groups only

Item	α = .05	α = .01
1	Jane >* Frank	Jane >* Frank
2	Frank > Joe	Frank > Joe
	Mary > Joe	Mary > Joe
	Frank > Jane	-
	Mary > Jane	-
3	Mary > Frank	-
	Jane > Frank	-
	Mary > Joe	-
	Jane > Joe	-
4	Joe > Frank	-
	Jane > Frank	-
5	Mary > Frank	Mary > Frank
	Joe > Frank	Joe > Frank
	Jane > Frank	Jane > Frank
9	Mary > Frank	Mary > Frank
	Joe > Frank	Joe > Frank
	Jane > Frank	Jane > Frank

* ">" signifies "scores significantly higher than". See text for interpretation.

It should be noted from Table 7.21 that no significant group x vignette interactions were found. Thus the patterning of between-vignette differences was not significantly different in the two groups. Further analysis of paired differences in vignette scores across each item shows that of the 54 possible differences (9 items x 6 pairs of vignettes), 15 were significantly different (paired T-Test, $\alpha = .05$, 2-tail) in the LRA and 12 in the HRA. These findings are clearly in accordance with the null hypothesis that there is no tendency to make finer distinctions between vignettes in one area compared to another. The alternative hypothesis of finer distinctions in the HRA finds no support.

Another set of hypotheses related to expected differences between groups on individual items of the CVI. Table 7.19 shows that there were significant ($p < .05$, 2 tail test) differences between group mean scores on eight items, and differences of borderline significance ($.10 < p > .05$) on a further five items. Differences on items 3 and 4 are in the expected direction, but differences on items 1, 2, 5, 7, 8 and 9 are in the opposite direction compared to our predictions. A summary analysis of findings between groups for each <u>set</u> of items (across vignettes) is given in Table 7.21. Significant trends were found for items 1, 2, 7 and 9 only. No other differences reached statistical significance. Thus, on items 3, 4, 5, 6 and 8 there is no evidence to reject the null hypothesis of no difference between groups; the alternative hypotheses are rejected. On items 1, 2, 7 and 9 the null hypothesis has indeed been refuted. However, <u>the direction of differences is diametrically opposed to that which was predicted on all four items</u>. Consequently, the alternative hypotheses also

have to be rejected. The tendencies discovered on each item of the CVI can be summarised as follows:

Item 1: HRA disagrees more than LRA with the statement that the act was understandable. (Note that the overall tendency is to disagree with the statement.)

Item 2: HRA disagrees less with the statement that S should be punished than LRA. (Note that both groups disagree overall with the idea of punishment.)

Item 3: Both groups disagree equally with the statement that "S did the right thing under the circumstances".

Item 4: Both groups hover around the mid-point ("Not Sure"), when asked to rate the statement "S could not help doing what she/he did ....".

Item 5: Both groups tend to disagree equally with the statement that "S really wanted to die ...." for cases Mary, Joe and Jane; both groups tend to agree equally with the statement for case Frank.

Item 6: Both groups express mild disagreement with the statement "Given the same problems, any man/woman might do what S did".

Item 7: HRA agrees more with the statement that the act is "morally wrong". (Note that both groups agree overall with the statement.)

Item 8: Both groups express mild disagreement with the statement that "What S did was one possible way of dealing with his/ her problems".

Item 9: Overall, HRA disagrees less with the statement ("S was trying to commit suicide") than LRA. (Note that on case Frank both groups tend to agree mildly with the statement; on the other three cases the HRA disagrees less with the statement than the LRA.)

Finally, we set out to look at the extent of consensus in each area. The null hypothesis posited no difference in levels of consensus between areas, whereas the alternative hypothesis predicted a greater degree of consensus in the HRA. Table 7.23 shows the distribution of responses across each item of the CVI, separately for each area. The "agree" and "strongly agree" responses have been merged into a single category, as have the "disagree" and "strongly disagree" responses. A visual inspection of this Table shows that the extent of consensus clearly differs across vignettes and across items. Adopting an arbitrary but reasonable criterion for deciding upon the presence or absence of consensus (present where ⩾33 of the group rate "strongly agree", "agree" or "not sure" OR "strongly disagree", "disagree" or "not sure"), we can examine the variability in consensus over items, vignettes and groups. Overall, fifteen items in the LRA and 13 items in the HRA are characterised by an absence of consensus. This difference is not significant. While the extent of consensus does not vary by vignette, certain items certainly generate more dissensus. Table 7.23 shows that there is a bimodal pattern of response on item 8 across all vignettes in the LRA, and all but one vignette in the HRA. The same absence of consensus is found on item 4 in three vignettes in each area; and on item 6 in two vignettes in each area. Only on items 2, 3, 5 and possibly 7 is there reasonable consensus in both areas. When responses in the two areas are compared, a significant level of agreement (r_s = .52, $p<.005$, 2-tail test) is found on the ranking of items according to the level of consensus. Overall, therefore, no evidence can be found to refute the null hypothesis of no difference in level of consensus on CVI items between area control groups.

Table 7.23. Distribution of responses across each item of CVI: Control groups compared

Item	HRA			LRA		
	Strongly Agree/ Agree	Not Sure	Strongly Disagree/ Disagree	Strongly Agree/ Agree	Not Sure	Strongly Disagree/ Disagree
M1	11	2	37	27	0	23
2	6	2	42	2	0	48
3	4	2	44	4	1	45
4	23	4	23	25	4	21
5	14	0	36	5	0	45
6	23	5	22	22	2	26
7	33	4	13	27	7	16
8	16	1	33	21	0	29
9	19	2	29	7	3	40
F1	22	1	27	29	1	20
2	6	3	41	1	0	49
3	10	1	39	4	0	46
4	32	3	15	21	4	25
5	29	2	19	32	3	15
6	19	3	28	18	2	30
7	40	2	8	26	6	18
8	21	2	27	23	0	27
9	33	3	14	33	4	13
JO1	16	3	31	24	3	23
2	12	2	36	7	1	42
3	6	1	43	4	2	44
4	23	0	27	19	4	27
5	16	4	30	10	2	38
6	15	3	32	15	2	33
7	38	2	10	32	4	14
8	18	3	29	27	0	23
9	20	3	27	8	5	37
JA1	17	2	31	19	3	28
2	7	2	41	5	1	44
3	4	2	44	3	1	46
4	26	3	21	15	4	31
5	17	2	31	11	2	37
6	15	4	31	16	3	31
7	36	1	13	28	4	18
8	20	1	29	19	0	31
9	21	2	27	11	3	36

7.8 Contact with Suicidal Behaviour: findings

Hypotheses relating to differential contact with suicidal behaviour in the two control groups were measured by means of the CSB instrument (see Appendix 6.8). Table 7.24 sets out the data required to test the hypotheses. In the first section of the Table inter-group differences on each item are considered. Only one result reached statistical significance ($p<.05$, 2-tail test): 24 of the LRA group had at least one lifetime contact with the suicide of a non-relation/close friend, in which there was no personal involvement, compared to 13 of the HRA group. None of the other eleven comparisons yielded significant results. The other sections of Table 7.24 consider a number of different composite measures of contact, but only two of these produce significant differences between control groups. Firstly, there was more contact with parasuicide or suicide of a close friend or relation in the HRA (33/50) than in the LRA (19/50). Secondly, there was more personally involved contact with parasuicide or suicide of a close friend or relation in the HRA (11/50) than in the LRA (2/50). A third difference was of borderline significance ($.10 < p > .05$): overall contact with parasuicide was greater in the HRA (36/50) than in the LRA (26/50). Lifetime contact with all forms of suicidal behaviour and threat was identical in the two groups: 40/50 in the LRA and 42/50 in the HRA. Likewise, there were no significant between-group differences on the amount of contact with threat, of contact with suicide, or contact with suicidal behaviour in a non-relation/close friend.

Table 7.24. Lifetime contact with suicidal behaviour: Control groups compared

Item			HRA (N)*	LRA (N)*	
Threat	No PI**	Not Friend/Relation	0	1	
Threat	No PI	Friend/Relation	2	2	
Threat	PI	Not Friend/Relation	1	2	
Threat	PI	Friend/Relation	3	7	
Parasuicide	No PI	Not Friend/Relation	18	11	
Parasuicide	No PI	Friend/Relation	21	14	
Parasuicide	PI	Not Friend/Relation	3	5	
Parasuicide	PI	Friend/Relation	8	2	
Suicide	No PI	Not Friend/Relation	13	24	$\chi^2=4.29$ df=1, $p<.05$
Suicide	No PI	Friend/Relation	9	6	
Suicide	PI	Not Friend/Relation	1	1	
Suicide	PI	Friend/Relation	3	0	
Threat	No PI		2	3	
Threat	PI		4	9	
Parasuicide	No PI		31	23	
Parasuicide	PI		10	7	
Suicide	No PI		20	27	
Suicide	PI		4	1	
All contact with THREAT			6	12	
All contact with PARASUICIDE			36	26	
All contact with SUICIDE			21	28	
All contact with PARASUICIDE/SUICIDE			40	40	
All contact with PARASUICIDE/SUICIDE/THREAT			42	40	
Personal Involvement with Parasuicide or Suicide - Friend or Relation			11	2	$\chi^2=5.66$ df=1, $p<.05$
Indirect contact with Parasuicide or Suicide - Friend or Relation			27	19	
All contact with Parasuicide or Suicide - Friend or Relation			33	19	$\chi^2=6.77$ df=1, $p<.01$

Table 7.24. continued ...

Item	HRA (N)*	LRA (N)*
Personal Involvement with Parasuicide or Suicide - Not Friend or Relation	3	5
Indirect contact with Parasuicide or Suicide - Not Friend or Relation	26	32
All contact with Parasuicide or Suicide - Not Friend or Relation	29	35

* Each person can score on >1 item, therefore totals for each section of the table exceed 50 in each group.

** PI = Personal Involvement

The relationship between contact with suicidal behaviour and the evaluation of parasuicide was explored in the following manner. A mean score for each item on the CVI (calculated by aggregating ratings on all four vignettes relating to the same item and dividing by four) was correlated with various composite measures derived from the CSB instrument. I examined a total of 126 correlations (14 composite contact variables x 9 mean vignette item scores) separately for each area. Not a single correlation reached the minimum level of statistical significance ($p<.05$, 1-tail test) in the LRA. In the HRA there was a negative association ($r = -.26$, $p<.05$) between scores on item 2 and a summary measure of contact with parasuicide: that is to say, the more extensive the contact with parasuicide, then the greater the likelihood of agreement with the statement that parasuicide should be punished. There was also a positive association ($r = .31$, $p<.05$) between scores on item 4 and a summary measure of contact with suicidal behaviour in a non-friend/relation: in other words, the more extensive such prior contact, the greater the likelihood of disagreement with the statement that parasuicide is something that happens to a person. These findings are in the opposite direction to that which was predicted. However, their importance should not be over-estimated. Only four of the 126 correlations in the HRA were significant, a number which could be expected by chance alone.

For the most part, therefore, there are no grounds for rejecting the null hypothesis of no difference between groups on the amount and nature of contact with different types of suicidal behaviour. The few differences that did emerge were, however, in the expected direction. Contact with parasuicide was higher in the HRA (though the result is of borderline significance only), and contact

(including personal involvement) with suicidal behaviour in a relative/close friend was also significantly higher in the HRA. Virtually no evidence of an association between contact and evaluation of parasuicide was discovered.

7.9 Conclusions

The testing of the major hypothesis has entailed a number of comparisons between HRA and LRA control groups on instruments measuring value orientations, norms, perception and definition of parasuicide, and contact with suicidal behaviour. The empirical evidence undoubtedly supports the prediction of a meaning system in the HRA which is distinctive from that found in the LRAs. However, not all the differences noted between the two groups are in the expected direction. What overall conclusions can we reach on the basis of the foregoing analysis?

(1) The sociodemographic differences between the groups are as expected, with LRA controls being of higher social class, more educated, more likely to own their own homes, and with a higher per capita disposable income. The HRA could call upon more relatives and friends in their local area; nevertheless, their feelings about the area itself were significantly more negative than those of their LRA counterparts. While such findings were not unexpected, the vehemence of antagonistic sentiments about the HRA among HRA controls was most pronounced. The implications of this will be discussed further in Chapter 9.

(2) The findings on the VOS were in the expected direction, with the LRA controls showing greater preference for Individualism (Relational Orientation), Mastery over nature (Man-Nature orientation), and an Optimistic view of Human Nature. However, the finding on the Human

Nature orientation was not repeated when analysis was carried out using the amended 4-item version VOS; and the null hypothesis on both the [Doing, Being] and [Pres, Future] dimensions could not be refuted.

(3) The Ways of Behaving Instrument provided evidence of a number of significant differences between area control groups in the normative evaluation of behaviour. However, there was also considerable overlap in the evaluative beliefs in the two groups. HRA controls were not found to rate more permissively (i.e. around the mid-point of the scale) than their LRA counterparts. In addition, there appeared to be little difference in the level of consensus in the two areas about whether a particular behaviour was in fact deviant or normative. The one unexpected finding which emerged was the particularly disvalued status of parasuicide in the HRA. Differentiation between area groups was considerably stronger on the expectation section of the WOBI. When the disjunction between evaluations and expectations was formally explored, the HRA demonstrated a significant trend towards higher absolute discrepancy scores.

(4) Findings on the Case Vignette Instrument were perhaps the most unexpected of all. There were differences in attitudes towards, and perceptions of, parasuicide vignettes in the two groups, but none in the predicted direction. To a significant degree, HRA controls tended to be less understanding of the behaviour, and to consider that it was more worthy of punishment and more immoral. They also perceived the actions of parasuicides to be significantly more suicidal or death-intended than did LRA controls. Again, not enough evidence exists to refute the null hypothesis of similar levels of consensus in the two areas. The implications of the inter-group differences on the CVI and the extent to which the findings are as unexpected as

they at first sight appear, are issues discussed further in Chapter 9.

(5) Overall, lifetime contact with suicidal behaviour was not found to be more extensive in the HRA than in the LRA. However, contact with parasuicide was reported by a greater proportion of HRA than of LRA respondents (this difference was of borderline significance); significantly more HRA respondents had experience of suicidal behaviour in a close friend or relation, and more reported a personal involvement in such an event. The only significant finding of more contact in the LRA group relates to suicide in a non-friend/relation without any personal involvement. Previous experience of suicidal behaviour appeared to exert no influence whatsoever on responses to the CVI in the LRA and the weak association between the two sets of variables in the HRA could have arisen by chance alone.

It should be noted that no evidence of the existence of a contraculture in the HRA has emerged. As expected, the differences between the two areas tend to be those of degree, not of kind. It is true that some alternative hypotheses were not supported, while others were actually refuted. This does not, however, alter the fact that the two groups did profess differences in value orientations, perceptions of parasuicide and normative evaluations and expectations of behaviour. To that extent, the major hypothesis of distinct cultural systems in the HRA and LRA has been supported and analysis can therefore proceed on the secondary hypothesis relating to within-area differences between patients and controls.

Chapter 8 SECONDARY HYPOTHESIS TESTED: WITHIN-AREA COMPARISONS

8.1 Secondary hypothesis restated

The secondary hypothesis of the present investigation has already been stated in Chapter 4, as follows:

> Differences in values, norms and other elements of the sub-cultural meaning system between parasuicides and the general population ("cultural distance") living in the HRA will be relatively smaller than the cultural distance between parasuicides and the general population in the LRAs. That is to say, LRA parasuicides are expected to be more culturally "deviant" in relation to the general population living in their area than are HRA parasuicides in relation to their local non-parasuicides.

The null hypothesis states that the cultural distance between patients and controls is similar in both area-types. Predictions relating to individual measures and instruments are not given here, since in all cases the alternative hypothesis states the likelihood of a significantly greater absolute difference between patients and controls in one area than another. The hypothesis does not refer to signed differences.

8.2 Statistical tests

Patients and controls within each area type are matched by age, sex and area of residence. The ascertainment of within-area differences between patients and controls on individual measures and instruments is therefore approached using statistical tests appropriate for such matched data. For categorical data, where the

dimensions of the table are 2x2, the McNemar Test for the significance of changes is the only suitable test available (see Siegel, 1956: 63-7). Maxwell (1971) has proposed an extension to the McNemar test which can be used for tables with more than four cells. Differences between patients and controls on measures based on continuous data are tested for significance by means of the paired T-Test. Where there is evidence of a non-significant correlation between mean scores in the two status groups, a non-parametric test is applied instead, usually the Wilcoxon Matched-Pairs Signed-Ranks Test (Siegel, 1956: 75-83). Throughout, the significance level (α) is set at .05, and sample sizes are 50 (pairs) in each area (although this maximum N is reduced for some analyses because of missing data). Differences between differences, i.e. the extent to which the difference between patients and controls in one area (LRA) exceeds that in the other area (HRA), are assessed by examining the significance of the interaction term in 2 way analyses of variance (area x status group). These analyses were specially programmed using a hierarchical design to take account of the fact that area groups (controls and patients) are independent, while within-area groups (controls versus patients) are correlated.

8.3 Demographic and social characteristics: findings

Patients and controls within each area were compared on all social and demographic characteristics. Table 8.1 shows that compared to their matched controls, patients in the LRA were significantly more likely to be of lower social class; less likely to be Protestant, and more likely to be Catholic or agnostic; less likely to be churchgoers; less likely to live with spouse; less likely to be owner-occupiers; likely to have lived in the area a shorter period

Table 8.1. Social and demographic characteristics: patients and controls compared in each area-type

Variable	LOW RATE AREA		HIGH RATE AREA	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
Mean age ..... years (S.D.)	30.5 (13.0)	30.5 (12.4)	28.3 (10.5)	29.5 (11.1)
Sex				
Male	21	21	18	18
Female	29	29	32	32
Marital status				
Single	20	19	19	15
Married/cohabiting	24	31	25	30
Separated/divorced/widowed	6	0	6	5
Time married/cohabiting				
⩽ 5 years	9	9	11	9
6-10 years	3	6	4	9
⩾ 11 years	11	15	8	12
Not known	1	1	2	0
(Not applicable)	(26)	(19)	(25)	(20)
Religion				
Protestant	25	40	30	37
Catholic	9	3 *	12	6
Other	2	4	2	1
None	14	3	6	6
Churchgoing				
At least weekly	1	9	2	3
At least monthly	4	7 *	1	0
At least once a year	5	11	9	8
Never	40	23	38	39
Birthplace				
Scotland	39	44	45	48
Elsewhere	11	6	5	2
Place where childhood spent				
Scotland	40	44	47	47
Elsewhere	10	6	3	3
Present employment status				
Working	37	37	26	33
Unemployed	4	0	14	2
Retired	3	1	1 **	1
Housewife only	2	5	7	13
Student	4	7	2	1

Table 8.1. continued ...

Variable	LOW RATE AREA				HIGH RATE AREA			
	Patients (N=50)		Controls (N=50)		Patients (N=50)		Controls (N=50)	
Number of jobs over past 5 years (including present one)								
1	18		20		11		18	
2	12		13		11		13	
⩾3	14		8		19		14	
(Not applicable/Not known)	(6)		(9)		(9)		(5)	
Education								
In education	3		7		2		1	
No qualifications	24		18		43		42	
Some qualifications	23		25		5		7	
Objective social class								
I	5		11		0		0	
II	13	31	20	41	2	10	4	11
III NonManual	13	*	10		8		7	
III Manual	10		5		16		15	
IV	7	19	2	9	16	40	17	39
V	2		2		8		7	
Subjective social class								
Lower	1		1		5		3	
Working	24	25	17	18	31	36	35	38
Middle	22		27		12		11	
Other (combination of above)	1		2		0		0	
"None"	1	3	3	5	0	2	0	1
"Don't Know"	1		0		2		1	
Household type								
Living with spouse/cohabitee	21		31		24		30	
Living with parent(s)	12		17		11		14	
Living with child(ren)	2		0		6		6	
Living with sibling(s)	0	*	0		1		0	
Living with other relative/ friend	9	17	1	2	5	15	0	6
In institution	2		0		0		0	
Alone	4		1		3		0	
Type of tenure								
Owner-occupied	25		40		3		5	
Rented from corporation	8	21	7	9	44	45	45	45
Rented for private landlord	13		2		1		0	
Lodgings	1	*	1		0		0	
Hostel	1		0		0		0	
Living with friend/relative	0	4	0	1	1	2	0	0
Other	2		0		1		0	

Table 8.1. continued ...

Variable	LOW RATE AREA		HIGH RATE AREA	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
Density				
⩽ 1.5 persons per room	46	49	43	43
> 1.5 persons per room	2	1	7	7
(Not applicable)	(2)	(0)	(0)	(0)
Time at present address				
⩽ 3 months	12	0	9	0
4-12 months	7	7	11	3
1-5 years	14	15	15	18
Over 5 years	17	28	15	29
Mean length of time at present address ..... months (S.D.)	69.8 (95.1)	* 112.4 (112.6)	57.8 (70.7)	** 116.2 (89.9)
Previous address				
Same ward	9	15	17	18
Other ward in Edinburgh	28	21	23	23
Elsewhere in Scotland	7	5	6	2
Outside Scotland	4	6	4	2
(Not applicable - born in house)	(2)	(3)	(0)	(5)
Number of addresses in past 5 years (including present one)				
1	17	29	16	29
2	14	* 10	19	** 12
⩾3	19	11	24	9
Mean net income (£) per person in household per week (S.D.)	48.42 (34.49)	40.58 (16.89)	25.89 (16.68)	25.64 (15.18)

[*] Significant difference between patients and controls in LRAs ($p<.05$, Maxwell's χ^2 test for matched pairs or paired T-Test)

[**] Significant difference between patients and controls in HRA ($p<.05$, Maxwell's χ^2 test for matched pairs or paired T-Test)

of time and to have moved more often in the past five years. Compared to their matched controls, HRA patients were more likely to be unemployed; likely to have lived in the area a shorter period of time and to have moved more often in the past five years. No significant difference between status groups in either area was found on the Local Bonds Scale (Table 8.2). While the difference in the mean score of status groups on the scale was higher in the HRA than in the LRA, the difference of the difference was not significant. Only on the item scoring mean N of relatives in the area was there a significant difference between HRA patients and controls: 1.86 versus 2.84, respectively (p=.Ø2). No significant difference was found on any item on the scale within the LRA. In relation to the Community Sentiment Scale, the LRA controls scored significantly higher than the LRA patients (3.2Ø versus 2.66, T=2.62, df 49, p<.Ø2), while the status groups in the HRA scored almost identically (mean score = 2.1Ø among patients, 2.Ø4 among controls). The only significant difference within the LRA on an individual item of the scale was found in answer to the question "Do you take an interest in the area?". Patients tended to take far less interest than controls (p<.Ø5). No significant difference on any item was noted in the HRA (see Table 8.3).

Summarising these results, we find six significant differences on demographic variables between patients and controls in the LRA compared to only three in the HRA. In addition, LRA patients and controls differed significantly in community sentiment, whereas there was no differentiation within the HRA. These findings are in accordance with our predictions. Overall, however, the null hypothesis of equal distance between patients and controls in the two areas could not be refuted with respect to the Local Bonds Scale.

Table 8.2. "Local Bonds": Patients and controls compared in each area-type

Variable	LRA		HRA	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
How many people do you know in the area?				
None	1	0	3	1
"Few" (<6)	16	10	15	14
"Lot" (>6)	33	40	32	35
Mean N. of friends in the area (S.D.)	1.50 (2.12)	1.40 (1.87)	2.06 (2.94)	2.04 (2.83)
Mean N. of relatives in the area (S.D.)	0.48 (1.13)	0.84 (1.70)	1.86 (2.15)	* 2.84 (2.44)
Local Bonds Scale** Score				
0	1	0	1	1
1	28	30	16	5
2	20	17	23	35
3	1	3	10	9
Mean Score (S.D.)	1.42 (0.58)	1.46 (0.61)	1.84 (0.77)	2.04 (0.61)

* Significant difference between patients and controls in HRA ($p<.05$, paired T-Test)

** For calculation of scale score, see Chapter 6.

Table 8.3. "Community sentiment": patients and controls compared in each area-type

Variable	LRA		HRA	
	Patients (N=50)	Controls (N=50)	Patients (N=50)	Controls (N=50)
Do you feel at home/ belong in the area?				
No	6	4	16	12
Yes	44	46	34	38
Is there a sense of community in the area?				
None	23	34	32	34
Some	7	10	6	6
A lot	14	4	8	8
(Don't know)	(6)	(2)	(4)	(2)
Feelings about the area?				
Satisfied	35	44	23	22
"Don't mind"	9	2	7	2
Dissatisfied	6	4	20	26
Interest in the area				
None	36	26	41	32
Some	4 *	15	4	12
A lot	10	9	5	6
How would you feel if you had to move away?				
Not sorry	23	13	27	26
Quite sorry	4 } 14	7 } 25	3 } 11	6 } 12
Very sorry	10 }	18 }	8 }	6 }
Depends ...	11 } 12	12 } 12	12 } 12	12 } 12
Mixed feelings	1 }	0 }	0 }	0 }
(Don't know)	(1)	(0)	(0)	(0)
Do you plan to move from area in near future?				
No	29	37	31	26
Possibly	11	8	6	4
Yes	7	5	11	20
Already moved	3	0	2	0
Community Sentiment Scale** score				
0	3	0	8	8
1	6	4	11	10
2	7 *	5	8	12
3	23	18	14	12
4	11	23	9	8
Mean Score	2.66	3.20	2.10	2.04
(S.D.)	(1.14)	(0.93)	(1.37)	(1.32)

* Significant difference between patients and controls in LRA ($p<.05$, Maxwell's χ^2 test for matched pairs or paired T-Test)

** For calculation of scale score, see Chapter 6.

8.4. Value Orientation Schedule: findings

Within-area comparisons were made on each dimension of the VOS (five item version). In addition, a hierarchical two-way (area x status group) analysis of variance was performed on each dimension, in order to test for the existence of interaction effects. Tables 8.4.1 to 8.4.11 give the results of these analyses. Considering, firstly, status differences within each area (Part A of each Table), only one significant finding emerged in the HRA, with controls being more future-oriented than patients on the [Pres, Fut] dimension. On the remaining ten dimensions, the two-tail probabilities associated with the t value were $p>.10$. In the HRA, there was one significant ($p<.05$) difference on the [With, Over] dimension and one difference of borderline significance ($.10 < p > .05$) on the [Coll, Ind] dimension: controls tended to evaluate Mastery over nature (Man-Nature orientation) higher than Harmony with nature, to a greater extent than patients; and controls tended to evaluate the Collateral pole (Relational orientation) higher than the Individualistic pole, to a greater extent than patients. Differences on the other nine dimensions were not significant at the $p<.10$ level.

The hierarchical analysis of variance (Part B of each Table) reveals significant ($p<.05$) area effects on six dimensions: [Pessimis, Optimis], [Lin, Ind], [Coll, Ind], [Past, Fut], [Subj, Over] and [With, Over]; and one area effect of borderline ($p<.10$) significance: [Past, Pres]. By contrast, there were significant ($p<.05$) status group effects on only two dimensions: [Subj, Over] and [Subj, With]; and one status group effect of borderline ($p<.10$) significance: [Pres, Fut]. No interaction term was significant at

Table 8.4. Hierarchical analysis of variance on dimensions of VOS (5 item version)*

Table 8.4.1 [Doing, Being] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance**
Patients	2.75	2.59	n.s.
Controls	2.74	2.79	n.s.
Significance***	n.s.	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	Ø.151	1	Ø.Ø89	n.s.
Error 1	166.263	98		
Status	Ø.451	1	Ø.26Ø	n.s.
Status x Area	Ø.552	1	Ø.318	n.s.
Error 2	169.872	98		

* N = 5Ø in each of the four cells throughout Table 8.4 (Total N = 2ØØ)
** Independent T-Test, 2-tail
*** Correlated T-Test, 2-tail

Table 8.4.2 [Lin, Coll] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	1.70	1.92	n.s.
Controls	1.94	1.82	n.s.
Significance	n.s.	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	0.125	1	0.122	n.s.
Error 1	100.820	98		
Status	0.245	1	0.265	n.s.
Status x Area	1.445	1	1.564	n.s.
Error 2	90.560	98		

Table 8.4.3 [Lin, Ind] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	1.89	2.Ø1	n.s.
Controls	1.84	2.36	<.Ø1
Significance	n.s.	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	5.12Ø	1	4.678	<.Ø5
Error 1	1Ø7.255	98		
Status	1.125	1	Ø.985	n.s.
Status x Area	2.ØØØ	1	1.752	n.s.
Error 2	111.875	98		

Table 8.4.4 [Coll, Ind] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	2.67	2.92	n.s.
Controls	2.55	3.34	<.ØØ1
Significance	n.s.	(<.1Ø)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	13.52Ø	1	9.525	<.Ø1
Error 1	139.1ØØ	98		
Status	1.125	1	Ø.991	n.s.
Status x Area	3.645	1	3.211	(<.1Ø)
Error 2	111.23Ø	98		

Table 8.4.5 [Past, Pres] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	Ø.71	1.Ø8	(<.1Ø)
Controls	Ø.65	Ø.83	n.s.
Significance	n.s.	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	3.781	1	3.833	(<.1Ø)
Error 1	96.683	98		
Status	1.2Ø1	1	1.52Ø	n.s.
Status x Area	Ø.451	1	Ø.571	n.s.
Error 2	77.473	98		

Table 8.4.6 [Past, Fut] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	Ø.98	1.26	n.s.
Controls	Ø.98	1.32	(<.1Ø)
Significance	n.s.	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	4.8Ø5	1	4.827	<.Ø5
Error 1	97.55Ø	98		
Status	Ø.Ø45	1	Ø.Ø43	n.s.
Status x Area	Ø.Ø45	1	Ø.Ø42	n.s.
Error 2	1Ø3.41Ø	98		

Table 8.4.7 [Pres, Fut] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	2.95	2.98	n.s.
Controls	3.36	3.12	n.s.
Significance	(<.10)	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	0.551	1	0.504	n.s.
Error 1	107.223	98		
Status	3.781	1	3.058	(<.10)
Status x Area	0.911	1	0.737	n.s.
Error 2	121.182	98		

Table 8.4.8 [Subj, With] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	3.00	3.05	n.s.
Controls	3.11	3.00	n.s.
Significance	n.s.	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	0.045	1	0.046	n.s.
Error 1	96.385	98		
Status	0.045	1	0.033	n.s.
Status x Area	0.320	1	0.233	n.s.
Error 2	134.385	98		

Table 8.4.9 [Subj, Over] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	2.48	2.85	n.s.
Controls	2.12	2.54	(<.10)
Significance	n.s.	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	7.801	1	4.228	<.05
Error 1	180.823	98		
Status	5.611	1	4.151	<.05
Status x Area	0.031	1	0.023	n.s.
Error 2	132.483	98		

Table 8.4.10 [With, Over] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	1.85	2.43	<.05
Controls	1.60	2.03	<.05
Significance	n.s.	<.05	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	12.751	1	7.713	<.01
Error 1	162.023	98		
Status	5.281	1	5.828	<.05
Status x Area	0.281	1	0.310	n.s.
Error 2	88.812	98		

Table 8.4.11 [Pessimis, Optimis] dimension

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	1.39	1.69	n.s.
Controls	1.45	1.87	<.05
Significance	n.s.	n.s.	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	6.480	1	6.827	<.05
Error 1	93.020	98		
Status	0.720	1	0.815	n.s.
Status x Area	0.180	1	0.204	n.s.
Error 2	86.600	98		

the .Ø5 level, and only one at the .1Ø level: the difference between HRA patients and controls on the [Coll, Ind] dimension was significantly greater than the difference on the same dimension between LRA patients and controls.

Summarising the analyses using the five-item version of the VOS, we can state, firstly, that the area main effect is more pronounced than the status group main effect: six significant ($p<.Ø5$) differences on dimensions (representing four value orientations) between areas, compared with two significant dimension differences (representing one value orientation) between status groups; secondly, that there is scant evidence of greater differences between patients and controls in one area than another: only one of the eleven dimensions showed an interaction effect (then only of borderline significance) and the "difference of the difference" was not in the expected direction.

A re-analysis of the data was undertaken, using the four-item version of the VOS. Overall, the findings were very similar to those derived from the five-item version. There were no significant interaction (area x status) terms on ten dimensions; on the [Coll, Ind] dimension the interaction was significant at $p<.Ø5$ (compared to $p<.1Ø$ in the original analysis). However, the absolute difference between mean scores of patients and controls in the HRA was approximately equal to the absolute difference between mean scores in the LRA. The significant interaction term arises out of the fact that the differences were in the opposite direction (+.27 in the HRA, -.29 in the LRA). Analysis using the four-item version also shows the same tendency for area effects to be more pronounced than status effects, although perhaps to a somewhat lesser extent. On

five dimensions the area effect reaches significance at p<.Ø5, and on a further dimension the effect is of borderline significance (p<.1Ø). On two dimensions the status effect is significant at p<.Ø5. The major differences between the four- and five-item analyses are listed below:

Dimension	5 item version			4 item version		
	Area	Status	Area x Status	Area	Status	Area x Status
[Lin, Ind]	<.05	n.s.	n.s.	<.10	n.s.	n.s.
[Coll, Ind]	<.01	n.s.	<.10	<.01	n.s.	<.05
[Past, Pres]	<.10	n.s.	n.s.	<.05	n.s.	n.s.
[Pres, Fut]	n.s.	<.10	n.s.	n.s.	n.s.	n.s.
[Pessimis]	<.05	n.s.	n.s.	n.s.	n.s.	n.s.

Both four- and five-item VOS analyses provide little evidence in support of the alternative secondary hypothesis, that the cultural distance between patients and controls in the LRA is greater than that in the HRA. The null hypothesis has not been refuted.

8.5 Ways of Behaving Instrument: findings

Comparisons between patients and controls were made on each evaluation and expectation item, separately for the LRA and the HRA. In addition, a hierarchical (area x status group) analysis of variance was performed on each item, in order to test for the existence of interaction effects. Tables 8.5.1 to 8.5.19 give the results appertaining to evaluation items; Tables 8.6.1 to 8.6.19, the

Table 8.5. Hierarchical analysis of variance of Evaluation items of WOBI*

Table 8.5.1 Item WOB1

(a) Cell means and t-test results

	LRA	HRA	Significance**
Patients	21.18 (21.18)	17.68 (17.68)	n.s. (N = 49,50)
Controls	23.60 (24.06)	15.58 (15.58)	<.05 (N = 50,50)
Significance***	n.s. (N = 49)	n.s. (N = 50)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	1777.312	1	7.743	<.01
Error 1	22265.375	97		
Status	6.500	1	0.021	n.s.
Status x Area	306.625	1	0.981	n.s.
Error 2	30303.875	97		

* Cell numbers vary because of missing values. For Patients and Controls (rows), N's refer to LRA and HRA, respectively. For LRA and HRA (columns), N refers to number of matched pairs. In each cell of Table, mean score in brackets is that used in matched pairs (within area) analysis. The mean score not in brackets is that used in the independent (across areas) analysis.

** Independent T-Test, 2-tail

*** Correlated T-Test, 2-tail

Table 8.5.2 Item WOB2

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	50.98 (50.77)	44.16 (44.16)	n.s. (N = 44,50)
Controls	60.20 (60.51)	37.72 (37.72)	<.001 (N = 49,50)
Significance	<.05 (N = 43)	n.s. (N = 50)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	9990.562	1	15.004	<.001
Error 1	60592.062	91		
Status	50.562	1	0.075	n.s.
Status x Area	3027.687	1	4.513	<.05
Error 2	61055.250	91		

Table 8.5.3 Item WOB3

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	49.91 (51.40)	53.57 (52.81)	n.s. (N = 44,49)
Controls	52.40 (51.21)	45.44 (45.34)	n.s. (N = 48,48)
Significance	n.s. (N = 42)	n.s. (N = 47)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	221.500	1	0.434	n.s.
Error 1	44370.125	87		
Status	724.062	1	1.269	n.s.
Status x Area	587.437	1	1.030	n.s.
Error 2	49637.000	87		

Table 8.5.4 Item WOB4

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	47.63 (47.63)	50.96 (51.00)	n.s. (N = 46,48)
Controls	52.86 (51.37)	52.15 (52.96)	n.s. (N = 50,48)
Significance	n.s. (N = 46)	n.s. (N = 46)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	282.437	1	0.522	n.s.
Error 1	48678.062	90		
Status	373.062	1	0.702	n.s.
Status x Area	36.562	1	0.069	n.s.
Error 2	47821.375	90		

Table 8.5.5 Item WOB5

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	36.67 (36.67)	38.18 (38.92)	n.s. (N = 46,49)
Controls	45.38 (45.26)	46.82 (46.75)	n.s. (N = 50,49)
Significance	<.05 (N = 46)	n.s. (N = 48)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	163.500	1	0.232	n.s.
Error 1	64878.812	92		
Status	3161.750	1	5.630	<.05
Status x Area	6.875	1	0.012	n.s.
Error 2	51666.875	92		

Table 8.5.6 Item WOB6

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	75.80 (76.40)	75.15 (75.44)	n.s. (N = 44,47)
Controls	81.53 (80.98)	83.58 (82.64)	n.s. (N = 49,48)
Significance	n.s. (N = 43)	n.s. (N = 45)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	5.000	1	0.011	n.s.
Error 1	37421.000	86		
Status	1542.000	1	3.792	(<.10)
Status x Area	76.000	1	0.187	n.s.
Error 2	34976.000	86		

Table 8.5.7 Item WOB7

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	56.11 (55.58)	51.35 (51.35)	n.s. (N = 47,49)
Controls	62.40 (60.33)	46.78 (46.78)	<.01 (N = 48,49)
Significance	n.s. (N = 45)	n.s. (N = 49)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	3711.312	1	5.542	<.05
Error 1	61607.562	92		
Status	0.500	1	0.001	n.s.
Status x Area	1020.375	1	1.544	n.s.
Error 2	60815.125	92		

Table 8.5.8 Item WOB8

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	82.25 (82.25)	81.42 (81.42)	n.s. (N = 48,50)
Controls	86.20 (86.67)	74.92 (74.92)	<.01 (N = 50,50)
Significance	n.s. (N = 48)	n.s. (N = 50)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	1937.000	1	3.933	(<.10)
Error 1	47281.000	96		
Status	65.000	1	0.156	n.s.
Status x Area	1459.000	1	3.499	(<.10)
Error 2	40035.000	96		

Table 8.5.9 Item WOB9

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	89.60 (89.60)	85.77 (85.55)	n.s. (N = 47,48)
Controls	89.16 (88.89)	79.73 (79.34)	(<.10) (N = 50,48)
Significance	n.s. (N = 47)	n.s. (N = 47)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	2172.000	1	4.510	<.05
Error 1	44310.000	92		
Status	562.000	1	1.525	n.s.
Status x Area	356.000	1	0.966	n.s.
Error 2	33913.000	92		

Table 8.5.10 Item WOB10

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	20.04 (20.04)	26.09 (26.98)	n.s. (N = 48,47)
Controls	16.42 (17.00)	20.54 (20.29)	n.s. (N = 50,48)
Significance	n.s. (N = 48)	n.s. (N = 45)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	1214.125	1	3.068	(<.10)
Error 1	36011.375	91		
Status	1074.187	1	2.610	n.s.
Status x Area	154.500	1	0.375	n.s.
Error 2	37452.812	91		

Table 8.5.11 Item WOB11

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	34.60 (33.58)	37.70 (36.38)	n.s. (N = 48,46)
Controls	40.64 (41.00)	43.65 (41.18)	n.s. (N = 47,49)
Significance	n.s. (N = 45)	n.s. (N = 45)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	99.812	1	0.202	n.s.
Error 1	43544.062	88		
Status	1680.562	1	2.362	n.s.
Status x Area	77.312	1	0.109	n.s.
Error 2	62622.125	88		

Table 8.5.12 Item WOB12

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	78.36 (77.98)	75.57 (75.09)	n.s. (N = 47,47)
Controls	86.78 (86.65)	81.92 (83.02)	n.s. (N = 49,49)
Significance	<.05 (N = 46)	n.s. (N = 46)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	489.000	1	0.843	n.s.
Error 1	52196.000	90		
Status	3172.000	1	6.715	<.05
Status x Area	6.000	1	0.013	n.s.
Error 2	42513.000	90		

Table 8.5.13 Item WOB13

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	84.44 (84.44)	82.56 (83.22)	n.s. (N = 48,50)
Controls	89.50 (90.06)	79.61 (79.61)	<.05 (N = 50,49)
Significance	n.s. (N = 48)	n.s. (N = 49)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	1650.000	1	3.808	(<.10)
Error 1	41163.000	95		
Status	45.000	1	0.105	n.s.
Status x Area	1033.000	1	2.416	n.s.
Error 2	40617.000	95		

Table 8.5.14 Item WOB14

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	45.34 (45.34)	45.30 (46.08)	n.s. (N = 44,50)
Controls	60.12 (61.82)	50.25 (50.25)	(<.10) (N = 50,48)
Significance	<.01 (N = 44)	n.s. (N = 48)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	1345.125	1	2.008	n.s.
Error 1	60294.437	90		
Status	4650.187	1	7.035	<.01
Status x Area	1739.562	1	2.632	n.s.
Error 2	59492.750	90		

Table 8.5.15 Item WOB15

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	25.93 (25.93)	27.13 (27.51)	n.s. (N = 46,48)
Controls	21.12 (21.67)	40.86 (39.47)	<.001 (N = 50,49)
Significance	n.s. (N = 46)	=.05 (N = 47)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	4361.187	1	5.819	<.05
Error 1	68197.000	91		
Status	720.187	1	1.084	n.s.
Status x Area	3057.375	1	4.602	<.05
Error 2	60451.437	91		

Table 8.5.16 Item WOB16

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	84.62 (84.34)	80.13 (80.18)	n.s. (N = 45,47)
Controls	84.94 (84.86)	89.32 (89.07)	n.s. (N = 49,47)
Significance	n.s. (N = 44)	<.05 (N = 44)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	0.000	1	0.000	n.s.
Error 1	28765.000	86		
Status	974.000	1	2.460	n.s.
Status x Area	769.000	1	1.942	n.s.
Error 2	34056.000	86		

Table 8.5.17 Item WOB17

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	21.19 (21.55)	22.32 (22.71)	n.s. (N = 48,50)
Controls	22.00 (21.06)	24.78 (24.78)	n.s. (N = 49,49)
Significance	n.s. (N = 47)	n.s. (N = 49)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	284.812	1	0.783	n.s.
Error 1	34179.687	94		
Status	31.687	1	0.073	n.s.
Status x Area	78.000	1	0.180	n.s.
Error 2	40789.312	94		

Table 8.5.18 Item WOB18

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	61.02 (61.02)	60.67 (60.67)	n.s. (N = 47,49)
Controls	71.02 (70.64)	59.58 (59.37)	<.05 (N = 50,50)
Significance	<.05 (N = 47)	n.s. (N = 49)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	1619.187	1	3.018	(<.10)
Error 1	50435.312	94		
Status	784.000	1	1.497	n.s.
Status x Area	1431.187	1	2.733	n.s.
Error 2	49222.812	94		

Table 8.5.19 Item WOB19

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	92.04 (92.04)	82.21 (80.93)	<.01 (N = 48,48)
Controls	90.28 (90.10)	85.91 (85.64)	n.s. (N = 50,45)
Significance	n.s. (N = 48)	n.s. (N = 44)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	2785.000	1	7.993	<.01
Error 1	31357.000	90		
Status	70.000	1	0.215	n.s.
Status x Area	506.000	1	1.553	n.s.
Error 2	29322.000	90		

Table 8.6. Hierarchical analysis of variance of Expectation items of WOBI*

Table 8.6.1 Item WOBl0l

(a) Cell means and t-test results

	LRA	HRA	Significance**
Patients	28.10 (28.10)	50.59 (49.82)	<.001 (N = 48,46)
Controls	30.32 (29.19)	44.14 (44.69)	<.05 (N = 50,49)
Significance***	n.s. (N = 48)	n.s. (N = 45)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	16087.125	1	16.149	<.001
Error 1	90649.750	91		
Status	172.312	1	0.232	n.s.
Status x Area	448.812	1	0.605	n.s.
Error 2	67524.375	91		

* Cell numbers vary because of missing values. For Patients and Controls (rows), N's refer to LRA and HRA, respectively. For LRA and HRA (columns), N refers to number of matched pairs. In each cell of Table, mean score in brackets is that used in matched pairs (within area) analysis. The mean score not in brackets is that used in the independent (across areas) analysis.

** Independent T-Test, 2-tail

*** Correlated T-Test, 2-tail

Table 8.6.2 Item WOB102

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	41.71 (41.07)	21.75 (21.75)	<.001 (N = 46,48)
Controls	52.40 (54.34)	17.06 (17.17)	<.001 (N = 48,50)
Significance	<.05 (N = 44)	n.s. (N = 48)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	36631.625	1	44.894	<.001
Error 1	73436.250	90		
Status	720.000	1	1.125	n.s.
Status x Area	3659.812	1	5.720	<.05
Error 2	57582.187	90		

Table 8.6.3 Item WOB103

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	34.71 (33.85)	23.50 (23.89)	<.05 (N = 49,48)
Controls	41.21 (41.24)	26.39 (26.47)	<.01 (N = 47,49)
Significance	n.s. (N = 46)	n.s. (N = 47)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	7106.000	1	12.743	<.001
Error 1	50746.312	91		
Status	1142.562	1	1.743	n.s.
Status x Area	269.687	1	0.411	n.s.
Error 2	59668.250	91		

Table 8.6.4 Item WOB104

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	25.45 (26.28)	20.07 (17.98)	n.s. (N = 44,44)
Controls	33.71 (35.77)	20.24 (17.76)	<.01 (N = 45,46)
Significance	(<.10) (N = 39)	n.s. (N = 41)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	6922.812	1	14.781	<.001
Error 1	36531.062	78		
Status	814.500	1	1.708	n.s.
Status x Area	941.687	1	1.975	n.s.
Error 2	37186.312	78		

Table 8.6.5 Item WOB105

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	33.64 (35.78)	43.33 (43.30)	n.s. (N = 44,46)
Controls	42.67 (43.76)	38.71 (38.39)	n.s. (N = 46,48)
Significance	n.s. (N = 41)	n.s. (N = 44)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	48.812	1	0.058	n.s.
Error 1	70199.937	83		
Status	72.375	1	0.089	n.s.
Status x Area	1761.812	1	2.156	n.s.
Error 2	67828.312	83		

Table 8.6.6 Item WOB106

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	82.39 (84.25)	69.61 (68.52)	<.05 (N = 41,38)
Controls	81.90 (84.10)	72.36 (72.36)	(<.10) (N = 49,42)
Significance	n.s. (N = 40)	n.s. (N = 33)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	6822.937	1	11.675	<.01
Error 1	41494.437	71		
Status	100.312	1	0.181	n.s.
Status x Area	144.562	1	0.261	n.s.
Error 2	39266.625	71		

Table 8.6.7 Item WOB107

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	44.09 (45.71)	37.26 (38.04)	n.s. (N = 47,46)
Controls	45.65 (46.89)	28.19 (26.42)	<.01 (N = 48,48)
Significance	n.s. (N = 45)	<.05 (N = 45)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	8904.187	1	9.492	<.01
Error 1	82548.062	88		
Status	1227.125	1	1.687	n.s.
Status x Area	1843.250	1	2.534	n.s.
Error 2	64018.625	88		

Table 8.6.8 Item WOB108

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	72.39 (72.39)	39.57 (39.57)	<.001 (N = 49,46)
Controls	84.43 (84.43)	51.78 (50.20)	<.001 (N = 49,50)
Significance	<.01 (N = 49)	(<.10) (N = 46)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	53341.937	1	54.816	<.001
Error 1	90498.937	93		
Status	6127.625	1	9.942	<.01
Status x Area	23.500	1	0.038	n.s.
Error 2	57317.375	93		

Table 8.6.9 Item WOB109

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	82.81 (82.81)	60.34 (62.00)	<.001 (N = 48,44)
Controls	84.80 (84.73)	73.63 (74.17)	<.05 (N = 50,48)
Significance	n.s. (N = 48)	<.05 (N = 42)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	11025.000	1	17.271	<.001
Error 1	56176.000	88		
Status	2020.000	1	3.528	(<.10)
Status x Area	1177.000	1	2.056	n.s.
Error 2	50379.000	88		

Table 8.6.10 Item WOB110

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	18.72 (18.72)	33.52 (32.93)	<.01 (N = 47,48)
Controls	20.94 (21.26)	29.88 (30.24)	(<.10) (N = 50,48)
Significance	n.s. (N = 47)	n.s. (N = 46)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	6253.750	1	9.920	<.01
Error 1	57365.812	91		
Status	0.125	1	0.000	n.s.
Status x Area	317.625	1	0.679	n.s.
Error 2	42551.750	91		

Table 8.6.11 Item WOB111

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	34.43 (35.00)	25.26 (25.14)	(<.10) (N = 40,46)
Controls	37.32 (39.68)	30.96 (30.09)	n.s. (N = 44,48)
Significance	n.s. (N = 34)	n.s. (N = 44)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	3627.500	1	4.792	<.05
Error 1	57535.625	76		
Status	911.062	1	1.336	n.s.
Status x Area	0.687	1	0.001	n.s.
Error 2	51840.750	76		

Table 8.6.12 Item WOB112

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	70.94 (72.27)	38.41 (38.41)	<.001 (N = 48,44)
Controls	79.38 (79.13)	40.39 (40.09)	<.001 (N = 47,49)
Significance	n.s. (N = 45)	n.s. (N = 44)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	59115.312	1	79.888	<.001
Error 1	64378.000	87		
Status	824.000	1	1.046	n.s.
Status x Area	299.062	1	0.380	n.s.
Error 2	68542.437	87		

Table 8.6.13 Item WOB113

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	76.93 (76.73)	42.55 (42.39)	<.001 (N = 48,47)
Controls	83.38 (83.81)	56.41 (56.02)	<.001 (N = 50,49)
Significance	n.s. (N = 48)	<.05 (N = 46)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	45334.000	1	46.781	<.001
Error 1	89153.625	92		
Status	4973.875	1	8.137	<.01
Status x Area	503.437	1	0.824	n.s.
Error 2	56233.187	92		

Table 8.6.14 Item WOB114

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	27.40 (27.36)	22.93 (23.90)	n.s. (N = 42,44)
Controls	38.82 (38.87)	26.61 (26.95)	<.05 (N = 45,46)
Significance	<.05 (N = 39)	n.s. (N = 40)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	2335.750	1	4.542	<.05
Error 1	39601.062	77		
Status	2063.562	1	3.799	(<.10)
Status x Area	707.125	1	1.302	n.s.
Error 2	41827.812	77		

Table 8.6.15 Item WOB115

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	33.96 (34.51)	38.38 (37.05)	n.s. (N = 46,45)
Controls	29.92 (30.76)	41.70 (40.38)	<.05 (N = 49,47)
Significance	n.s. (N = 45)	n.s. (N = 42)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	1606.625	1	2.316	n.s.
Error 1	58976.625	85		
Status	4.750	1	0.007	n.s.
Status x Area	545.937	1	0.779	n.s.
Error 2	59560.812	85		

Table 8.6.16 Item WOB116

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	81.11 (82.26)	60.92 (61.47)	<.001 (N = 45,38)
Controls	84.79 (84.98)	63.66 (63.53)	<.001 (N = 47,44)
Significance	n.s. (N = 43)	n.s. (N = 34)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	16932.437	1	20.755	<.001
Error 1	61185.937	75		
Status	226.875	1	0.376	n.s.
Status x Area	4.375	1	0.007	n.s.
Error 2	45264.250	75		

Table 8.6.17 Item WOB117

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	36.07 (37.83)	47.06 (47.00)	(<.10) (N = 45,47)
Controls	33.66 (32.95)	42.24 (41.43)	n.s. (N = 47,49)
Significance	n.s. (N = 42)	n.s. (N = 46)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	3419.250	1	3.616	(<.10)
Error 1	81327.250	86		
Status	1207.437	1	1.456	n.s.
Status x Area	5.187	1	0.006	n.s.
Error 2	71323.875	86		

Table 8.6.18 Item WOB118

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	43.94 (43.94)	25.75 (25.75)	<.001 (N = 48,48)
Controls	55.54 (56.88)	33.12 (31.50)	<.001 (N = 50,50)
Significance	<.05 (N = 48)	n.s. (N = 48)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	22772.312	1	35.020	<.001
Error 1	61124.187	94		
Status	4190.625	1	5.705	<.05
Status x Area	620.000	1	0.844	n.s.
Error 2	69044.875	94		

Table 8.6.19 Item WOB119

(a) Cell means and t-test results

	LRA	HRA	Significance
Patients	81.65 (82.09)	51.49 (51.81)	<.001 (N = 46,45)
Controls	82.90 (82.32)	64.09 (61.88)	<.001 (N = 48,46)
Significance	n.s. (N = 44)	(<.10) (N = 42)	

(b) Analysis of variance: summary

	s.s.	d.f.	F ratio	2-tail significance
Area	27638.062	1	32.533	<.001
Error 1	71360.875	84		
Status	1089.937	1	2.081	n.s.
Status x Area	1041.250	1	1.988	n.s.
Error 2	43999.312	84		

results appertaining to expectation items.

If we examine first the within-area T-Test comparisons, we find that there were five significant (p<.Ø5) differences within the LRA on evaluation items (WOB2, WOB5, WOB12, WOB14, WOB18) and two in the HRA (WOB15, WOB16). Turning to the expectation section, we discover four significant differences in the LRA (WOB1Ø2, WOB1Ø8, WOB114, WOB118), plus one difference of borderline (p<.1Ø) significance (W1Ø4). In the HRA, there were three items with significant differences (WOB1Ø7, WOB1Ø9, WOB113) and one of borderline significance (WOB119).

The hierarchical two-way analysis of variance reveals significant (p<.Ø5) area effects on six evaluation items: WOB1, WOB2, WOB7, WOB9, WOB15 and WOB19; and four area effects of borderline (p<.1Ø) significance: WOB8, WOB1Ø, WOB13 and WOB 18. Once again, fewer status effects are found: significant on three items (WOB5, WOB12, WOB14) and of borderline significance on one item (WOB6). On two items (WOB2 and WOB15), there were significant interaction terms and on a further item (WOB8) the F score was of borderline significance. On item WOB2, the difference between mean patient and control scores was greater in the LRA, whereas on items WOB8 and WOB15 it was greater in the HRA. On items WOB2 and WOB8, however, the significance of the interaction term is due more to the fact that within-area differences have different signs in the two areas, than that the difference in one area is absolutely greater than the difference in the other area. Only on item WOB15 is there any evidence of a greater absolute difference within the HRA than within the LRA: the within-area difference in mean scores is -4.26 in the LRA and +11.96 in the HRA.

Findings relating to the Expectation section follow the pattern noted above (primacy of area effect over status effect and little evidence of interaction), but to a more marked degree. Significant ($p<.05$) area effects were found on all but three items, and on one of these (WOB17) the effect was of borderline ($p<.10$) significance. Thus only on items WOB105 and WOB115 was the area effect absent. By contrast, only three expectation items (WOB108, WOB113 and WOB118) showed a significant status effect, while on two items (WOB109 and WOB114) the status effect was of borderline significance. Only one significant interaction item was found. On item WOB102 the difference in mean scores within the LRA was +13.27 ; within the HRA it was −4.58.

Overall, Tables 8.5 and 8.6 demonstrate conclusively that the two areas are characterised by different normative expectations and, to a lesser extent, normative evaluations. Some differences between patients and controls are present, but to a markedly lesser degree. Out of 38 items, only three reveal a significant interaction effect. On two of these items the absolute difference between patient and control mean scores is higher in the LRA (WOB2, WOB102), and on one item the absolute difference is higher in the HRA (WOB15). On the basis of these results, it is not possible to refute the null hypothesis of no difference in "cultural distance" in the two area-types. The alternative hypothesis (more "cultural distance" in the LRA) finds no support.

8.6 Case Vignette Instrument: findings

Table 8.7 shows mean scores for each status x area group on each item of the CVI. Significant ($p<.05$) and borderline significant ($p<.10$) differences are noted, both between status groups and within areas. It can be seen that there was a tendency for more differences between patients and controls to be found in the LRA than in the HRA. There were significant differences on twelve items in the LRA, and only five in the HRA. In both areas, there were six differences of borderline significance (see Table 8.7). However, a two-way (area x status group) hierarchical analysis of variance analysis on each item failed to disclose a single significant interaction effect. (Analysis not shown here.)

The three-way (area x status group x vignette) hierarchical analysis of variance on each item is given in Table 8.8 (see Chapter 7 for empirical evidence in support of the use of the case vignette item as the basic unit of analysis). A significant area effect was found on items 1, 2, 7, 8 and 9. All items except 5 and 8 showed a significant status group effect (the effect on item 8 was, in fact, of borderline significance), and all items except 7 showed a significant vignette effect. There were no significant interactions between area and status group, or vignette and status group, nor any three way interaction effect. Only one significant interaction between vignette and area was found (plus another of borderline significance on item 5). We can therefore conclude once again that the null hypothesis of no difference in cultural distance between areas has not been refuted. No evidence to support the alternative hypothesis - that cultural distance is greater in the LRA than in the

Table 8.7. Case Vignette Instrument: Mean Scores in Each Area x Status Group

Variable	Low Rate Area		High Rate Area		Significance of difference*			
	Patients (N = 50)	Controls (N = 50)	Patients (N = 50)	Controls (N = 50)	Within LRA	Within HRA	Between Patients	Between Controls
Mary 1	3.02	2.94	3.22	3.62	ns	ns	ns	<.01
2	4.62	4.44	4.36	4.14	ns	ns	ns	(<.10)
3	4.08	4.24	3.84	4.16	ns	(<.10)	ns	ns
4	2.14	2.94	2.14	3.00	<.01	<.001	ns	ns
5	3.70	4.12	3.62	3.58	<.05	ns	ns	<.05
6	2.86	3.20	2.88	3.08	ns	ns	ns	ns
7	3.24	2.68	2.70	2.50	<.05	ns	<.05	ns
8	3.00	3.32	3.58	3.60	ns	ns	<.05	ns
9	3.34	3.94	3.20	3.24	<.05	ns	ns	<.01
Frank 1	2.40	2.82	2.66	3.16	(<.10)	<.05	ns	ns
2	4.62	4.50	4.24	3.96	ns	ns	<.05	<.001
3	3.68	4.12	3.76	3.80	<.05	ns	ns	(<.10)
4	2.24	3.18	2.24	2.68	<.001	(<.10)	ns	<.05
5	2.48	2.62	2.64	2.78	ns	ns	ns	ns
6	2.78	3.30	2.80	3.26	<.01	<.05	ns	ns
7	3.12	2.88	2.72	2.26	ns	<.05	ns	<.01
8	2.50	3.12	3.32	3.32	<.01	ns	<.001	ns
9	2.08	2.54	2.24	2.54	(<.10)	ns	ns	ns
Joe 1	2.82	3.06	3.40	3.40	ns	ns	<.05	ns
2	4.46	4.06	3.98	3.74	<.05	ns	<.05	ns
3	3.66	4.04	3.74	3.90	(<.10)	ns	ns	ns
4	2.94	3.26	2.76	3.14	ns	ns	ns	ns
5	3.30	3.82	3.50	3.42	<.05	ns	ns	ns
6	3.10	3.46	3.04	3.46	(<.10)	ns	ns	ns
7	3.04	2.66	2.66	2.30	ns	ns	ns	ns
8	2.70	2.96	3.12	3.38	ns	ns	ns	(<.10)
9	3.50	3.82	3.06	3.20	ns	ns	ns	<.05
Jane 1	2.92	3.26	3.42	3.46	ns	ns	<.05	ns
2	4.44	4.12	4.22	3.92	(<.10)	(<.10)	ns	ns
3	3.92	4.24	3.74	4.16	(<.10)	<.05	ns	ns
4	2.60	3.46	2.54	2.98	<.001	(<.10)	ns	<.05
5	3.76	3.80	3.42	3.44	ns	ns	ns	ns
6	2.96	3.34	3.00	3.42	<.05	(<.10)	ns	ns
7	3.20	2.82	2.82	2.40	ns	(<.10)	ns	(<.10)
8	3.06	3.42	3.30	3.40	ns	ns	ns	ns
9	3.64	3.74	3.10	3.24	ns	ns	<.05	(<.10)

*Within areas : Paired T-Test, 2-tail significance.
Between areas: Independent T-Test, 2-tail significance.
ns: p>.10

Table 8.8. Hierarchical analysis of variance on items of CVI: Summary analysis*

Table 8.8.1 Item 1

	s.s.	d.f.	F ratio	2-tail significance
Area	30.031	1	11.406	<.01
Error 1	258.043	98		
Status	10.809	1	4.791	<.05
Status x Area	0.004	1	0.002	n.s.
Error 2	221.062	98		
Vignette	31.543	3	9.388	<.001
Vignette x Area	0.852	3	0.254	n.s.
Vignette x Status	3.574	3	1.063	n.s.
Vignette x Status x Area	4.805	3	1.430	n.s.
Error 3	658.477	588		

* Cell mean scores are not presented because of complexity of analysis (three-way). See Table 8.7. for mean scores on each item in each area x status group. Significant differences (between and within areas) are also given in Table 8.7.

Table 8.8.2 Item 2

	s.s.	d.f.	F ratio	2-tail significance
Area	22.781	1	11.844	<.001
Error 1	188.496	98		
Status	13.262	1	6.873	<.05
Status x Area	0.004	1	0.002	n.s.
Error 2	189.109	98		
Vignette	13.445	3	9.975	<.001
Vignette x Area	1.926	3	1.403	n.s.
Vignette x Status	0.664	3	0.483	n.s.
Vignette x Status x Area	0.660	3	0.480	n.s.
Error 3	269.055	588		

Table 8.8.3 Item 3

	s.s.	d.f.	F ratio	2-tail significance
Area	2.418	1	1.211	n.s.
Error 1	195.687	98		
Status	15.680	1	7.852	<.01
Status x Area	0.406	1	0.203	n.s.
Error 2	195.664	98		
Vignette	9.242	3	5.258	<.01
Vignette x Area	0.473	3	0.270	n.s.
Vignette x Status	0.570	3	0.324	n.s.
Vignette x Status x Area	2.645	3	1.505	n.s.
Error 3	344.570	588		

Table 8.8.4 Item 4

	s.s.	d.f.	F ratio	2-tail significance
Area	5.117	1	1.942	n.s.
Error 1	258.203	98		
Status	79.379	1	24.342	<.001
Status x Area	2.004	1	0.615	n.s.
Error 2	319.617	98		
Vignette	32.199	3	13.170	<.001
Vignette x Area	2.820	3	1.153	n.s.
Vignette x Status	6.121	3	2.503	n.s.
Vignette x Status x Area	3.418	3	1.396	n.s.
Error 3	478.941	588		

Table 8.8.5 Item 5

	s.s.	d.f.	F ratio	2-tail significance
Area	4.500	1	1.880	n.s.
Error 1	234.500	98		
Status	4.203	1	1.508	n.s.
Status x Area	3.645	1	1.308	n.s.
Error 2	273.152	98		
Vignette	154.109	3	44.379	<.001
Vignette x Area	8.207	3	2.364	(<.10)
Vignette x Status	1.047	3	0.302	n.s.
Vignette x Status x Area	3.508	3	1.010	n.s.
Error 3	680.629	588		

Table 8.8.6 Item 6

	s.s.	d.f.	F ratio	2-tail significance
Area	Ø.Ø12	1	Ø.ØØ4	n.s.
Error 1	317.1Ø5	98		
Status	3Ø.Ø31	1	12.43Ø	<.ØØ1
Status x Area	Ø.Ø31	1	Ø.Ø13	n.s.
Error 2	236.812	98		
Vignette	9.Ø16	3	3.37Ø	<.Ø5
Vignette x Area	Ø.344	3	Ø.129	n.s.
Vignette x Status	1.223	3	Ø.458	n.s.
Vignette x Status x Area	Ø.324	3	Ø.121	n.s.
Error 3	524.344	588		

Table 8.8.7 Item 7

	s.s.	d.f.	F ratio	2-tail significance
Area	33.617	1	5.607	<.05
Error 1	587.633	98		
Status	28.125	1	6.977	<.01
Status x Area	0.047	1	0.012	n.s.
Error 2	395.078	98		
Vignette	2.348	3	1.370	n.s.
Vignette x Area	0.715	3	0.416	n.s.
Vignette x Status	0.066	3	0.038	n.s.
Vignette x Status x Area	2.199	3	1.282	n.s.
Error 3	336.172	588		

Table 8.8.8 Item 8

	s.s.	d.f.	F ratio	2-tail significance
Area	27.008	1	6.025	<.05
Error 1	439.336	98		
Status	11.758	1	3.100	(<.10)
Status x Area	4.355	1	1.148	n.s.
Error 2	371.762	98		
Vignette	16.660	3	7.379	<.001
Vignette x Area	4.668	3	2.068	n.s.
Vignette x Status	0.520	3	0.230	n.s.
Vignette x Status x Area	2.418	3	1.071	n.s.
Error 3	442.484	588		

Table 8.8.9 Item 9

	s.s.	d.f.	F ratio	2-tail significance
Area	24.148	1	9.926	<.Ø1
Error 1	238.426	98		
Status	13.781	1	4.6Ø5	<.Ø5
Status x Area	2.312	1	Ø.773	n.s.
Error 2	293.281	98		
Vignette	171.363	3	49.792	<.ØØ1
Vignette x Area	12.555	3	3.648	<.Ø5
Vignette x Status	1.922	3	Ø.559	n.s.
Vignette x Status x Area	2.355	3	Ø.684	n.s.
Error 3	674.555	588		

HRA - has been forthcoming.

8.7 Contact with Suicidal Behaviour: findings

Within-area comparisons were carried out in respect of differences in the extent and type of contact with suicidal behaviour. Overall, a similar proportion of respondents in all area x status groups reported some contact during their lifetime with suicide, parasuicide or threatened suicide: 40 patients and 40 controls in the LRA; 44 patients and 42 controls in the HRA. There was a (non-significant) tendency for LRA respondents to have more contact with suicide than HRA respondents, and for HRA respondents to have more contact with parasuicide than LRA respondents. But within each area, no differences between patients and controls emerged. Similarly, there was a (non-significant) tendency for contact with suicidal behaviour (suicide, parasuicide) by a close friend or relative to be more pronounced in the HRA than in the LRA; while contact with non-friends/relations was higher in the LRA than in the HRA. The differences between patients and controls on these variables did not reach statistical significance. For a summary of the major findings, see Table 8.9. These data do not refute the null hypothesis of no difference in "cultural distance" in the two area types.

8.8 Conclusion

Detailed analyses of within-area differences relating to all the measures and instruments employed in this study suggest that there is little support for the alternative secondary hypothesis. That is to say, overall it is not possible to refute the null hypothesis, which

Table 8.9. Lifetime Contact with Suicidal Behaviour: Within-Area Comparisons

	Low Rate Area		High Rate Area	
	Patients (N = 50)	Controls (N = 50)	Patients (N = 50)	Controls (N = 50)
All contact with THREAT	7	12	10	6
All contact with PARASUICIDE	29	26	34	36
All contact with SUICIDE	24	28	17	21
All contact with PARASUICIDE AND SUICIDE	40	40	42	40
All contact with THREAT, PARASUICIDE AND SUICIDE	40	40	44	42
All contact with PARASUICIDE/SUICIDE - Close friend/relation	25	19	33	33
All contact with PARASUICIDE/SUICIDE - not Close friend/relation	28	35	18	29

predicts no difference in "cultural distance" (between patients and controls) across the two area-types. The only evidence favouring the alternative hypothesis is somewhat tangential, relating to demographic and social variables, and the Community Sentiment Scale. There certainly appear to be grounds for concluding that LRA patients are less typical of their neighbours than are HRA patients of their neighbours in relation to these measures. However, before arriving at such a conclusion, we need to bear in mind the findings (reported in Chapter 5) relating to the representativeness of the achieved parasuicide sample in each area. Evidence was produced to demonstrate that the LRA interviewed (achieved) patients were more representative of the LRA patient cohort from which they were taken, than were HRA interviewed patients of the HRA cohort. The implication of this finding is that a greater number of "deviant" patients were missed from the HRA sample of cases than from the LRA sample of cases. Nevertheless, if we examine the significant differences between patients and controls in each area and attempt to allow for the known unrepresentativeness of the patient samples, we find that we are still left with evidence of greater differentiation in the LRA. The LRA patient sample was representative on all demographic variables of the LRA cohort, with the sole exception of marital status. The failure to find significant differences in marital status between LRA control and patient groups may be an artefact due to the underrepresentation of single patients in the achieved patient sample. The HRA patient sample was unrepresentative only on two variables: social class and employment status. Consequently, the finding of significantly more unemployment among HRA patients than their matched controls is particularly impressive, while the failure to find a difference on social class may be a false negative due to the omission from the achieved sample of a

disproportionate number of class IV and V individuals. The findings in both areas of differences between patients and controls on length of time in the area and number of moves over the past five years may to some extent be an artefact arising out of the use of the general practitioner age-sex register as the sampling frame. Since the process of registration can take a few months, the sampling frame for the choice of controls would be less adequate in its coverage of those with short lengths of stay in the area.

Apart from this evidence of greater atypicality in the patient sample in the LRA than in the HRA, the findings, relating to the VOS, WOBI, CVI and Contact schedules are not supportive of the alternative hypothesis. Overall, we can only conclude that the null hypothesis - no difference in cultural distance between patients and controls across areas - is not refuted.

Chapter 9 DISCUSSION AND CONCLUSION

In this study I have applied survey-type methodology to evaluate the hypothesis of a subculture of parasuicide and, more generally, the cultural status of parasuicidal behaviour. Predictions were made about the nature and content of the subculture and its likely location. In this discussion I shall attempt to answer the two major questions to which such a focus gives rise:

(1) Have I established the existence of the putative subculture?

(2) If so, is the content of the subculture congruent with the relatively high incidence of parasuicide in the area where the subculture is found?

9.1 On the existence of the putative subculture

The impetus for, and origins of, this study arise out of the multiple standardisation exercise of Buglass and colleagues (Buglass et al., 1970). They discovered that variation in parasuicide rates between city wards in Edinburgh could not be wholly accounted for by the differing sociodemographic features of these areas, and suggested that the cultural meaning system of certain communities might in some way be associated with the high rates of parasuicide and other officially deviant behaviours that characterise them. Buglass et al did not explicitly state their views on a number of issues which are of paramount importance for setting up an empirical test of such a hypothesis. In particular, did they have in mind a subculture or a contraculture in the high-rate parasuicide areas? Did they tend towards a position of normative determinism (a parasuicidal subculture) or rather of the co-existence of deviant and official

value systems in a symbiotic relationship (a subculture of parasuicide)? What, precisely, were the expected cultural features of the high-rate area relevant to the (relatively) high incidence of parasuicide? How was the existence of the subculture to be assessed? To what population (referent) was the subculture expected to apply?

There is, of course, no reason why Buglass and colleagues should have attempted to answer such questions, and my intention in listing them has not been to criticise the original study. On the contrary, it is most refreshing to come across a carefully formulated empirical exercise which can not only decisively refute a null hypothesis (differences in parasuicide rates between areas are "due to" differences in the sociodemographic characteristics of the areas) but also put forward such a provocative and fascinating suggestion to explain the results in a manner which allows a fresh empirical test in its turn. However, these questions do require careful consideration and detailed responses, since the discovery or failure to discover the putative subculture depends on the manner and methods with which it is sought.

At a very early stage in the planning of this research, two fundamental decisions were taken: firstly, to frame the hypothesis in terms of the existence of a subculture conducive to parasuicide (in certain specified high-rate areas of Edinburgh), rather that a contraculture which required the behaviour; and secondly, to assess the content of the subculture by means of a survey type methodology employing quantitative measurement techniques. The implications of these decisions need to be explicated in full.

Somewhat confusingly, Buglass et al. claim that their usage of the subculture concept is in line with Wolfgang and Ferracuti's (1967) postulate of the subculture of violence

> "where the resort to physical violence is more acceptable, and is considered appropriate to a wider variety of situations than would be the case in society at large." (Kreitman, 1977: 63)

However, Wolfgang and Ferracuti maintain that while the subculture of violence notion does not require that actors sharing the value system should express violence in all situations, the normative system does designate that in some types of social interaction a violent and physically aggressive response is either expected or required by members of the subculture. On the other hand, Buglass and colleagues state categorically that:

> "This is not to claim that parasuicide is normative in any culture ..." (Kreitman, 1977: 63)

Following Matza's (Matza, 1964) distinction, we can state that, while Wolfgang and Ferracuti clearly have in mind a violent subculture, Buglass and colleagues appear to be postulating a subculture of parasuicide (notwithstanding the use of the term "parasuicide subculture" (Kreitman, 1977: 66)).

We have seen (pp 59-60) that two hypotheses can be elicited from the suggestions made by Buglass et al. on the subculture of parasuicide. Firstly, that the incidence of parasuicide is related to its normative evaluation within a community; and, secondly, the incidence of parasuicide is related to certain elements or central

tendencies in the community subculture or meaning system. Quite rightly, there is no suggestion that parasuicide itself is seen as a collective solution to problems or that it forms the central focus of such a subculture. However, the nature and content of the subculture, the manner in which its various elements cohere and relate to the incidence of suicidal behaviour, remains to be specified.

To the extent that Buglass and colleagues were indeed postulating the existence of a subculture, rather than a contra-culture, and eschewing altogether a normatively deterministic position, my own conceptualisation of the issue is largely in agreement with theirs. I started my investigation from the premise that I was seeking the existence of a cultural system that bore some recognisable and measurable relationship to the mainstream culture, rather than expressing a dramatically oppositional set of values, norms, etc. This starting-point was the outcome not only of my interpretation of Buglass and colleagues' remarks, but also out of my (somewhat limited) knowledge of the areas where such a cultural system might flourish and a conviction that true contracultures (in Yinger's terms) are somewhat rare in real life. The work of Rodman, Hannerz and others led me to expect differences of emphasis, style and degree rather than of kind between the subculture and the dominant culture. At no point in the execution of the study did I find evidence of an oppositional meaning system in areas of high parasuicide rates. Nevertheless, had such a contraculture in fact existed, it would not have been overlooked as a result of the particular choice of methodology which was made.

The definition of subculture adopted in the study (see pp 17-

21) stresses the need to examine all major features or elements of the meaning system, both behavioural and ideational; the requirements of some degree of cohesiveness and coherency between the various elements, and their differentiation from the dominant culture; and the importance of examining mechanisms of diffusion through informal contact and role-modelling and not merely via parental transmission. I rejected the validity of the distinction between subcultural and situational explanations of behaviour, which might well have ruled out a priori the "culturalness" of suicidal behaviour. I expressed agreement (p 30) with Fine and Kleinman's view that the subculture must be tied to a more exact referent than a population identified by standard demographic variables. The referent should also be characterised by "effective interaction". However, I rejected their contention that survey research cannot provide an adequate operationalisation of the subcultural referent.

At a general level, I do not find Klein and Fineman's argument wholly convincing. While it is acceptable to state that the presence of a subculture cannot be inferred from relative agreement on a set of values, etc., nevertheless it is still the case that without evidence of such agreement the ontological status of the subculture must be questionable, to say the least. The question then becomes: What is the best way for establishing the strength of consensus on these elements among culture carriers? In my view, Fine and Kleinman do not make out a persuasive case against survey methodology. There is no logical impediment to the exploration of distinctive cultural elements such as customs and behaviours by means of interviews with respondents. Clearly, the data will not consist of unbiassed observations of others' behaviour, but rather the perceptions of others' behaviour as reported by a (possibly prejudiced) informant. But,

then, we no longer labour under the naive conviction that the sociological observer is any less of a biassed perceiver of reality than the member of the culture which he is observing. Moreover, at least the range of members' distortions is necessarily circumscribed by the cultural system in which they are embedded, whereas those of the observer may or may not be. Observation and participant observation techniques are not inherently free from the risks of misunderstanding and misinterpreting subcultures or contracultures which espouse values deeply at odds with those of the observer. Contrariwise, the use of somewhat impersonal methods (e.g. questionnaire) in an interpersonal setting (e.g. face-to-face interview) may elicit strongly held feelings and attitudes which are felt to be deviant or abnormal.

Finally, I adopted a quantitative survey methodology precisely because I became convinced of the need to measure features of culture, such as the strength of agreement on norms and values, in as objective, reliable and replicable a manner as possible. I did not believe that a more traditional ethnographic approach would have allowed me to quantify subjective data with a similar degree of objectivity. (That is not to deny that both types of methodology would have been preferable to the use of one type alone. But time and scarce resources precluded this ideal solution.) I felt that a more "hard-nosed" approach was necessary because it was more likely to produce valid and reliable measures of cultural features, minimise problems of response and acquiescence set (or, at least, permit the extent of such problems to be assessed), be sensitive to differences between groups that might exist, and produce replicable/refutable results. To the extent that these aims have been achieved, the method has been vindicated.

However, before assessing empirical evidence concerning the extent of agreement in the putative subculture of parasuicide on attitudes, values, etc., I want to consider whether the referent of the subculture can be shown to possess a shared common identification and whether communication occurs within the population segment. We will recall that these latter features are a sine qua non, according to Fine and Kleinman, for inferring the presence of a subculture. Here we have to draw on information from respondents provided during the interview, and on observations by the author and others who have some knowledge of the HRA.

The relevant empirical data from the study are summarised in Tables 7.3 (p 227) and 8.3 (p 289). Compared to the LRA respondents, inhabitants of the HRA are significantly less satisfied with the area, less concerned about having to move away, more likely to move anyway. Overall, among control groups the LRA respondents' mean Community Sentiment Scale score is over 50% higher than that of HRA respondents. However, even these striking findings fail to do justice to the depth of feeling expressed by HRA informants about the stigma attached to residence in the area. The fifty individuals, who were chosen at random (within certain constraints) from the area population and who form the referent for the subculture, were fundamentally united in their perception of the area, their perception of its public image and their perception of themselves as its inhabitants. While none of them would claim to be deserving of the labels attached (or perceived to be attached) to them by the wider Edinburgh community, they commonly identified the roles they had been assigned: those of marginal, pariah and outcast. The opinions expressed to me fully endorsed the picture of the area

presented in the Pilton Study (see Chapter 5, section 1.5).

It is not difficult to find many other examples in the literature of "hard-to-let" estates such as Pilton (particularly, West Pilton). Damer (1974) undertook participant observation work in "Wine Alley", a small Corporation slum-clearance housing estate in the Govan area of Glasgow. Within a year of the newcomers' arrival (in 1934), Wine Alley was already perceived by the long-term resident Govanites and the Corporation as a "problem estate" because of the high levels of rent arrears, vandalism, delinquency, crime and psyco-social problems prevalent in the area. Its inhabitants were typified as deviants, a reputation persisting to the present day. The locals in Wine Alley, on the other hand, look back on the early days of the estate with great nostalgia: it was a happy place to live in, indeed, it "was perceived as a paradise by the first settlers" (Damer, 1974: 234). Although locals were aware of the pejorative labels applied to them and the area by the Govanites, they felt that the labels were not legitimate. About the end of the Second World War, changes for the worse began to appear in the social picture of the estate. According to the locals, in the post-war years 'anti-social' families began to arrive in the estate. They were the ones responsible for the gradual destruction of the physical environment. The Corporation are accused both of neglecting the estate and also permitting 'anti-social' families to move in. However, Damer can find no evidence to suggest that Wine Alley was deliberately used as a 'dumping-ground' for 'anti-social' families. "I am in fact in no doubt that a 'dumping' policy did <u>not</u> occur." (Damer, 1974: 236; emphasis in original). Nevertheless, the perception of the locals was certainly that their estate was used as a "dumpin-ground [for] riff-raff" (p 237). When the author tried to locate the riff-raff,

he was always pointed to another part of the housing scheme. Deviants were seen to be everywhere, but not in the informant's locality. In such a setting, there exists a generalised suspicion directed at those living at the furthest point away from the individual. Damer notes the combination of familial introversion (i.e. the 'safe' world of the nuclear family and close friends) and verbal extraversion (intense gossip about the reputation of other families in the neighbourhood):

> "People retreat to their homes, and the house becomes a haven, as Rainwater [1968] puts it, whence the outside world of neighbours and co-residents is scanned with suspicion. The point about Wine Alley, and similar housing estates, is that one is forced into interaction with one's neighbour, whether he is desirable or not. It is thus difficult to avoid moral contamination and 'trouble' through the anti-social behaviour of a limited number of people, and as one is frequently unsure of their location, territorial withdrawal and suspicion are the mechanisms used by Wine Alley people to deal with the uncertainty of their everyday life." (Damer, 1974: 239)

Other ethnographies of similar "problem estates" differ in their emphases, but also stress poor public image of the area, its high rates of deviance, the residents' lack of attachment to the community, the prevalence of mutual distrust and suspicion, and the evidence of gross material and environmental deprivation. Thus Rainwater (1970a) refers to the extent of crime, delinquency and scandal, the "tangle of pathology", to be found in the Pruitt-Igoe public housing project in St. Louis, U.S.A. "Pruitt-Igoe houses families for which our society seems to have no other place" (p 9).

Only those desperate for housing are willing to live there, even though the apartments themselves are considered to be better than those from which the residents have moved. The project is felt to be unsafe; people are continually confronted with dangers from human and non-human sources. The majority of tenants demonstrate no real attachment to the community. Further discussion and examples of "problem estates" and their characteristics can be found in Spencer (1964), Armstrong and Wilson (1973a, 1973b), Baldwin (1974), Department of the Environment (1981).

At a more general level, these types of estates have been described as "dreadful enclosures" (Walter, 1972, quoted in Damer, 1974) and "defeated neighbourhoods" (Suttles, 1972). The author of the term "dreadful enclosure" observes:

> "In all parts of the world, some urban spaces are identified totally with danger, pain and chaos ... certain milieux gather reputations for moral inferiority, squalor, violence, and social pathology, and consequently they objectify the fantasy of the dreadful enclosure." (See Damer, 1974: 221)

In his important book The Social Construction of Communities, Suttles (1972) contrasts the defended neighbourhood and the defeated neighbourhood. The former is most commonly the smallest area which possesses a corporate identity known both to the members and to outsiders. It can be conceived of as the smallest spatial unit within which co-residents assume a relative degree of security on the streets as compared to adjacent areas. Suttles notes two major strategies for a new resident in a defended neighbourhood: select an area where the character of fellow residents is assured by the cost

of living there (a choice available only to high income groups); or, cultivate neighbours once one is in an area to the point where they come to share a "personal covenant" (a strategy more common among the disadvantaged and the discriminated). However, as Suttles points out, some people can follow neither strategy because they cannot afford to move and they so thoroughly distrust their "disreputable" neighbours that they are unwilling or unable to cultivate them. Such communities tend to be very fragmented, composed of isolated families. This type of community Suttles calls the defeated neighbourhood. It is an undefended area, open to invasion by any sort of resident, and treated by local and government agencies as an object without much fear of retaliation from a local constituency. The major weakness in its defence is the fact that it is "unable to participate fully in its own governance"; the heavily stigmatised and outcast residents are too ashamed to engage in any form of participation. Suttles gives as examples of such defeated neighbourhoods, housing projects and "Skid Row".

I would suggest that the Pilton area, and in particular West Pilton, is indeed an example of a defeated neighbourhood. Residents share a common perception and identification of themselves and their locality as heavily stigmatised and disvalued by the surrounding Edinburgh community. In common with Damer (1974) (but contrary to what Suttles appears to imply), I could find no evidence that residents had internalised or accepted the pejorative labels attached to them. They know about these labels and personally suffered the consequences of bearing a Pilton address, but they either rejected their validity or claimed that they rightfully applied only to others. Nevertheless, by virtue of this perceived common stigma, practical problems of travel, the presence of a number

of key relatives and friends locally (see Table 7.2, p 226), Pilton residents tend to interact and communicate with others in the area. The conditions and constraints which circumscribe their lives force them into some form of social intercourse with their neighbours. It is therefore concluded that a reasonable prima facie case can be made out for the existence of communication and shared common identification among members of the population segment in the Pilton area.

It is now necessary to consider the extent of consensus within the putative subculture. This issue was considered in some detail in the discussion about the measurement of norms (pp 159-171). There it was noted that no sociologist would insist upon complete agreement before granting the label "norm" to a particular evaluative belief. Likewise, some degree of dissensus on cultural items (norms, attitudes, values, etc.) among informants forming the referent of a subculture is not incompatible with the existence of subculture itself. But how much disagreement can we accommodate before we have to relinquish the idea of a subculture and refer instead to a discrete and disparate collection of individuals? Rather than set some arbitrary figure which would be unlikely to command widespread support, I propose to make use of the research design in order to provide some answer to the question. The HRA is held to be characterised by a distinctive subculture while the LRAs are chosen as representative of the dominant culture. The HRA is not an entirely homogeneous area in its sociodemographic and environmental features, but the majority of parasuicide patients (and therefore controls) reside in the central and western districts (West Pilton, Muirhouse, Pennywell) which do share a number of such features in common. The LRAs, despite sharing a reasonably similar social class

profile and parasuicide rate, differ in a number of ways. It will be recalled that Table 5.2 (pp 87-88) demonstrates some degree of differentiation between Corstorphine and Murrayfield-Cramond, on the one hand, and Newington, on the other. It is therefore to be expected that informants from the putative subculture of parasuicide will tend to show more agreement on measures of their cultural meaning-system than do informants from the LRAs. To the extent that the reverse is true, then two possibilities have to be considered. Firstly, that no such subculture exists; or, secondly, that the method of sample selection and the small size of the interviewed groups makes any firm conclusion on the matter somewhat problematic.

The major findings on consensus were presented in Chapter 7. On the VOS, the HRA control group failed to show a significant patterning on nine (out of 25) items, while LRA controls failed to agree on seven (Table 7.4, p 236). On the Evaluation section of the WOBI no consensus was discovered on four items (out of 19) among HRA controls, compared to two items among LRA controls (Table 7.15, p 256). The figures relating to the Expectation section of the WOBI were three and four, respectively (Table 7.17, p 261). Finally, there was no consensus on thirteen (of the 36) items of the CVI in the HRA and on fifteen items in the LRA. None of these inter-group differences were significant. The overall number of items registering no consensus in these three instruments was virtually identical in the two areas: 29 (out of 99) in the HRA compared to 28 in the LRA. There is therefore no evidence to refute the null hypothesis of no difference in consensus between area control groups, and no support for the alternative hypothesis of greater consensus in the HRA. This equivocal result rules out any peremptory dismissal of the HRA control group as a subculture referent. However, since we

cannot state definitely whether the area control groups are representative of their populations (see Chapter 5, pp 106-119), this issue clearly requires further study, either by use of different methodology and techniques and/or by gathering a considerably greater sample of respondents (see Chapter 10).

9.2 On the content of the subculture of parasuicide

In this section I intend to assess the extent to which the content of the subculture of parasuicide can be said to be congruent with the high incidence of parasuicide in the area. Two separate issues will be considered: firstly, the central tendencies or themes of the meaning system; and, secondly, the normative evaluation of parasuicide.

The themes of the subculture of parasuicide are a confusing mixture of the expected and the unexpected - or rather it would be more accurate to say the predicted and the non-predicted, since a number of non-predicted results appear, with hindsight, to be predictable and unexceptional. The VOS results (four-item version - see Table 7.11, p 249) show that, compared to the LRA, the HRA subculture expresses a significantly greater preference for the Collateral principle in personal relationships and for a feeling of Subjugation or fatalism when confronted with life's problems. The discovery of these preferences in the HRA was predicted, not only because they are held to be quintessential themes of working/lower class culture, but also because they dovetail so closely with characteristic features of the parasuicidal act itself. With reference to parasuicide, the salience of collaterality in personal relationships is evidenced by the fact that the most common

precipitant of the act has been shown to be "interpersonal conflict", a broad category which includes marital discord, kin disharmony, broken/unhappy love affair, dispute with parents, infidelity, etc. (see Kessel et al., 1975; Morgan et al., 1975; Fieldsend and Lowenstein, 1981; Adam et al., 1978; Paykel et al., 1975; Paykel, 1980). A number of observers put forward the view that a primary (albeit often unconscious) purpose of the self-harmful behaviour is to attempt to re-establish bonds of love and friendship with those from whom the subject feels estranged. Cantor (1972: 253) notes that "[i]t is common to find suicide attempts described as affiliative acts", while Henderson (1974) highlights the "care-eliciting" component in parasuicide. Fatalism and powerlessness have been shown to be associated with parasuicide or "suicide potential" in several clinical studies (e.g. Wenz, 1975, 1977; Goldney, 1982; Farnham-Diggory, 1964).

However, the VOS (four-item version) fails to confirm the predictions of a greater degree of preference for a Pessimistic view of human nature or for a Present time orientation or for an emphasis on action and activity (Doing) in the HRA. It will be recalled that the themes of action (rather than contemplation) and impulsively (rather than long-term planning) were held to be characteristic features of the subculture of parasuicide (Kreitman, 1977: 63-64). Certainly these themes are found repeatedly in the literature on working/lower-class subculture (see Table 4.2, p 75). Moreover, in his review Neuringer (1978) presents clinical evidence which demonstrates that the organisation and perception of time is peculiarly distorted by suicidal individuals.

"Evidently, fixation on the present and crippling of the

capacity to deal with the future are hallmarks of the suicidal individual's temporal orientation." (Neuringer, 1976: 244).

However, while no preference was expressed in the HRA for the Present time and Doing alternatives on the VOS, it may still be the case that actual behaviour in the HRA reveals a tendency to impulsivity and avoidance of contemplation. The findings on the Expectation section of the WOBI are consistent with such a possibility.

The Ways of Behaving Instrument portrays two communities which broadly agree on evaluations of different behaviours, yet at the same time hold contrasting expectations about their actual occurrence in the particular locality. The statistically significant differences between LRA and HRA control groups on evaluative items have been shown to be somewhat misleading, inasmuch as the overall evaluative tendency is similar in the two sociocultural milieux. The various conduct norms have been grouped together a priori in a number of analytic categories which relate to alleged "themes" of the working class subculture. An examination of inter-group differences/ similarities in relation to these "themes" produces some unexpected findings. Items WOB1, WOB2 and WOB4 tap the existence of a "non-deferred gratification pattern" in the HRA. Only the ratings on item WOB2 are in the expected direction. Item WOB1 can be interpreted as evidence of a greater willingness to defer in the HRA, while group mean scores are almost identical on item WOB4. Violence toward self (WOB6, WOB16) is evaluated in identically negative fashion in both areas. Conflict and violence in family relationships (WOB3, WOB9, WOB11, WOB19) are negatively evaluated in the two areas, and only on item WOB9 in the LRA rating significantly more extreme. The

importance of sharing worries (WOB15) is given significantly weaker emphasis by HRA respondents, but the other item on confiding of problems (WOB5) is rated similarly in the two areas. Contrary to expectation, the HRA subculture is significantly more tolerant of women working outside the home (WOB7), and no differences were found between areas in the evaluation of male participation in household activities. The item tapping integration into society (WOB10) was similarly evaluated in the two areas. As predicted, toughness and trouble (WOB8, WOB12 and WOB13) and use of alcohol and drugs (WOB14, WOB18) were less negatively evaluated in the HRA to a significant degree. Evidence of the existence in the HRA of that distinctive ethos which is held to characterise the working/lower-class subculture is thus somewhat conflicting. The most surprising findings relate to self-violence and the non-deferred gratification pattern. However, the failure to differentiate groups on NDGP is consistent with the finding of similar ratings on the [Present, Future] dimension of the VOS (four-item). We should also remind ourselves that not all social scientists accept that the NDGP is a distinguishing feature of lower/working-class life (see, e.g., Miller et al., 1969).

However, the normative aspect of culture includes collective expectations as well as collective evaluations of behaviour and striking evidence of inter-group differences on expectation items was indeed uncovered. Over the whole range of behaviours the discrepancy between evaluation and expectation ("absolute discrepancy score") was significantly more pronounced in the HRA. I noted previously (p 263) that the magnitude of this discrepancy was first taken to signify the extent of "social disorganization", as defined by Cavan (1928: 330): "the loss of control of mores over the

members of the group". A low absolute discrepancy score means little or no social disorganisation. Evaluations and expectations are in harmony; the mores are perceived to influence behaviour. This type of norm corresponds to Gibbs' "collective convention" (Gibbs, 1965: 592 - see p 162 above). On the other hand, a high mean score on this variable is evidence of a perceived failure of the norms to exert any influence over behaviour. Strongly held collective views about the rightness or wrongness of an act may indeed exist, and be recognised by the group, but equally they are not perceived to be effective in controlling actual behaviour in the community. This type of norm corresponds to Gibbs' "problematic convention" (Gibbs, 1965: 592 - see p 162 above). The findings reported in Table 7.18 (p 264) could therefore be interpreted as evidence of greater social disorganisation in the HRA.

Another possible interpretation of these data is that they affirm the existence in the HRA of a divergence between aspirations (evaluations) and behavioural norms (expectations) which is largely absent in the LRA. Gans (1968) criticises the traditional cultural view of social and personal change because it

> "identifies culture in terms of how people act; it views values as <u>behavioural norms</u> that are metaphysical and moral guidelines to behaviour, and are deduced from behaviour. This definition, useful as it is, pays little or no attention to <u>aspirations</u>, values that express the desire for alternative forms of behaviour." (p 207; emphasis in original).

Gans notes that researchers tended to make no distinction between norms and aspirations. The most extreme position was taken by Miller

(1958), who implied that lower-class aspirations as well as norms are different from those of the rest of society. However, the debate among anthropologists over whether Carribean lower-class couples in consensual relationships preferred formal marriage (see, e.g. Rodman, 1966; Goode, 1960) led to the recognition that lower-class or poor individuals share many of the aspirations of the middle-class and affluent, but also develop norms that justify their actual behaviour. Rodman (1963) conceptualises this divergence between aspirations and norms as lower-class value stretch (although I prefer to use the more general concept "normative stretch", in order to emphasise that the same phenomenon can be discovered in other elements of the culture). Rainwater (1970b) argues that the lower-class share the aspirations of the larger society, which he calls conventional norms. Knowing that they cannot live up to them, however, they develop other norms that fit the existential conditions to which they must adapt. Because of the considerable divergence between behavioural norms and aspirations, Gans (1968) believes that it is

> "clearly impossible to think of a holistic lower-class culture. It is perhaps possible to describe a behavioural lower-class culture, consisting of the behavioural norms with which people adapt to being poor and lower class. There is, however, no aspirational lower-class culture, for much evidence suggests that poor people's aspirations are similar to those of [the] more affluent ...." (p 213; emphasis in original).

Applying this perspective to the WOBI findings, it can be plausibly suggested that members of the subculture of parasuicide share dominant norms and values but also develop an alternative normative focus which minimises the social and psychological cost of

deviation from the mainstream meaning system. To the extent that behaviour which is "deviant" (in an evaluative sense) is also perceived to be fairly widespread, then its performance is less likely to invoke sanctions or to be viewed as evidence of individual pathology. Whilst not being a preferred or normative mode of action, parasuicide (or any of the other deviant behaviours) may be viewed as cultural in the HRA precisely because of its perceived high profile or visibility. It is available as part of a repertoire of behaviours which are not only equally or more negatively evaluated in the LRA but also less "veridically familiar" (Ginsburg, 1971: 201) to LRA residents. As Hannerz (1969: 186-7) notes:

> "[W]e can probably assume that [the] very occurrence [of an act] can be taken to indicate that at least the actor involved regards it as an appropriate mode of behavior. In the absence of any information to the contrary, the prospective learner who happens to be present will thus assume that this is a permissible way of behaving. To put it another way, doing something in the presence of others is not merely doing that something but also communicating a way of doing it, and furthermore, it is a communication that it is in all probability an acceptable way of doing it."

Although the findings from the CSB instrument do not support the hypothesis that contact with suicidal behaviour <u>in general</u> is more widespread in the subculture of parasuicide than in the other areas, there is nevertheless evidence to suggest that the <u>quality</u> of contact is significantly different. In particular, HRA controls report a greater degree of personal involvement and a greater likelihood of experiencing suicidal behaviour in a close relative or

friend. Contact with parasuicide was also shown to be more extensive among HRA than among LRA controls. These results certainly support the contention that parasuicide is more veridically familiar in the HRA. What is somewhat surprising is the scanty evidence of any relationship between prior contact with suicidal behaviour and attitudes towards, and evaluations of, parasuicide, as measured in the Case Vignette instrument. Contrary to expectations, the findings relating to the HRA suggest that more contact may be associated with less sympathetic, more punitive attitudes. (However Sale et al. (1975) also found that respondents who reported personal contact with "attempted suicide" were more likely to have hostile attitudes.)

Thus far we have only considered the central tendencies or themes in the HRA subculture and their relationship to the level of parasuicide in the area. I now turn to the question of the normative status of parasuicide itself. If the picture which emerges from the previous discussion on the general content of the subculture is only partly in line with our predictions, the Case Vignette Instrument has certainly produced even more unexpected findings. Compared to LRA controls, members of the HRA subculture find the parasuicidal act less understandable, more deserving of punishment, more morally wrong and more suicidal. Furthermore, self-harmful behaviour was evaluated as more deviant (compared to other deviant behaviours) in the HRA than in the LRA. That is to say, it appears to have a specially disvalued status in the HRA. The level of consensus about the normative status of parasuicide and suicide was also exceptionally higher in the HRA.

These more negative attitudes towards, and different perceptions of, parasuicide among HRA controls cannot be accounted for by diff-

erential experience of suicidal behaviours nor by the greater expectation of suicide and parasuicide in the area. But are these findings, although unpredicted, as unexpected as they appear at first sight?

Many investigators examining public perceptions of, and attitudes towards, mental illness have started out with the hypothesis of greater toleration of abnormal behaviour in the lower social classes (e.g. Hollingshead and Redlich, 1958; Freeman and Simmons, 1963). However, Dohrenwend and Chin-Shong (1967) point out that the evidence is ambiguous, and could just as easily be interpreted as proof of less tolerance of mental disorder among lower-status respondents. They also draw attention to the fact that attitudes towards other types of deviant behaviour tend to be more intolerant among lower-educated, lower-status groups. According to Miller and Riessman (1961: 91), the stable American worker, "While ... somewhat radical on certain economic issues, ... is quite illiberal on numerous matters, particularly civil liberties and foreign policy." Lipset (1959: 483) claims that "[m]any studies suggest that the lower-class way of life produces individuals with rigid and intolerant approaches to politics." Cohen and Hodges (1963) found that while the lower-middle class stratum in their sample proved least forgiving of violations of conventional morality (e.g. drunkenness, swearing), the lower-lower stratum was most harsh in condemnation of other sorts of deviants: the atheist, the homosexual, the "un-American", the radical, and the artist-intellectual. Above all lower-class antipathy was directed towards the ethnic minority group. On the other hand, numerous studies (see Table 4.3, p 76) have claimed to demonstrate a greater tolerance of deviant behaviour in slum or lower-class areas.

Dohrenwend and Chin-Shong remain puzzled by the acceptance of the notion that there is greater tolerance in the lower-class of mentally disturbed behaviour, when the evidence is conflicting and inconclusive. They ask whether it is because the notion somehow accords with the prevailing stereotypes of lower-class life. They themselves suggest, on the other hand, that lower status-groups are predisposed to greater intolerance of the kinds of deviance that both they and higher status groups define as mental illness. They point out that because a high rate of deviant behaviour is found in a group, this does not imply that such behaviour is tolerated by the group- tolerated in the sense of evoking sympathetic or indulgent attitudes. They claim that there are two other possibilities. Firstly, that the group does not share the norms of the wider society - i.e. they are not reacting to deviance as they see it. Secondly, that the behaviour may be seen as deviant, but the reaction is one of fearful immobility or apathy, rather than sympathy.

The WOBI analysis has clearly ruled out the likelihood of a radically different meaning system in the HRA: the discovery of value or normative stretch cannot be regarded as evidence of the existence of a contraculture. To the extent that parasuicide is perceived to be significantly more expected behaviour in the HRA, and the disjunction between evaluation and expectation of parasuicide is significantly greater in the HRA, then its normative status in the subculture is more ambiguous. Nevertheless, there is little indication that HRA controls do not view the behaviour as deviant. In fact, we should recall that in the HRA parasuicide is the most proscribed of all behaviours listed in the WOBI; and that the majority of HRA members consider parasuicide to be both deviant and

unlikely in the eyes of the local community.

Dohrenwend and Chin-Shong's second possibility deserves more consideration. They distinguish between three meanings of tolerance: sympathy, sufferance and allowing something. By the latter Dohrenwend and Chin-Shong are referring to the possibility that behaviour is merely permitted in a passive sense. The fact that there is consensus in the HRA as much as in the LRA that parasuicide should not be punished is compatible with this possibility (even though HRA controls are significantly less likely to disagree with the idea of punishment). That is to say, while attitudes are negative, sanctions may not be invoked to deal with the behaviour. It may be seen as a "fact of life" which, though deplored, is not thought to warrant intervention. It is less understandable in the HRA; perhaps there exists no clear idea about why it occurs and what can be done to prevent it. (No consensus was found among HRA controls on item 4 of the CVI). Feelings of hopelessness, fatalism, pessimism and apathy, which are typical of dreadful enclosures such as West Pilton, are not likely to be accompanied by a strong conviction that any of the common deviant behaviours can be changed or eradicated, or that members of the subculture can effect such changes. However, while this portrait of the subcultural reaction to officially deviant behaviour may be valid overall, it is still necessary to account for the unexpected finding of the particularly disvalued and extreme status of suicidal behaviour (compared to other deviant behaviours) in the HRA.

A number of other possibilities are worth considering in trying to explain the seeming discrepancy between the greater frequency of parasuicide and its more negative evaluation in the HRA compared to

the LRA. The first starts off from the premise that parasuicide is perceived as deviant by both parasuicidal and non-parasuicidal members of the subculture, and that strong public feelings are expressed when it occurs. It is precisely its markedly deviant status that ensures that the act is performed in certain conditions where an extreme form of behaviour is thought to be required, i.e. a behaviour which is unlikely to be ignored or passively accepted. As we have seen, the most common precipitant of parasuicide is interpersonal conflict, particularly in a context of mutual hostility and resentment. For many parasuicides, the self-harm is consciously or subconsciously "used" in an attempt to restore broken or damaged social relationships. It is an "affiliative act", an extreme form of "care-eliciting behaviour", undertaken when other acts would be unlikely to achieve the desired changes in the inter-personal environment, either because they would be misunderstood or could be ignored or would not be fruitful in the specific cultural context (Sale et al., 1975; Cantor, 1972). Two difficulties immediately come to mind with regard to this possible explanation of the discrepancy between parasuicide incidence and evaluation in the HRA. Firstly, we have to reconcile the notion of parasuicide as an attempt to "shock" significant others with the known impulsivity and lack of planning characteristic of the act. This is not as problematic as it appears at first sight. Even when the parasuicide appears "impulsive" it has frequently been rehearsed beforehand in the imagination. Furthermore, the shock value of the act is not dependent upon the fact that it has been carried out deliberately or consciously. Behaviour is no less cultural because it is performed impulsively. If parasuicide is indeed part of the behavioural repertoire among subcultural members then to a large extent it does carry a preformed meaning whose power and significance is not

lessened by any element of deliberateness or impulsivity in its performance. The second difficulty is that while most parasuicides occur in an interpersonal context, a minority of self-harmful acts appear to have no exogenous cause or to be precipitated by non-interpersonal events or difficulties. Perhaps for this group the normative evaluation of parasuicide is not relevant.

Another possible explanation of the discrepancy between incidence and evaluation of parasuicide in the HRA is that, while the behaviour is perceived to be deviant, the existence of other constraints serves to negate or attenuate the strength of negative feelings against parasuicide. Objective and subjective conditions of life (e.g. the stigma of living in a dreadful enclosure, poverty, poor housing, lack of support, perceived inadequacy of support, hostile environment) exert pressures on interpersonal relationships and personal self-concepts leading in turn to a felt need for resolution or respite. Parasuicide is available for use in certain stressful circumstances, and, in spite of its deviant status, it occurs when pressure becomes too great and other escape routes are blocked or simply not available in the subculture. In other words, it is suggested that parasuicide is a pragmatic escape route and not intended (consciously or subconsciously) as a shock weapon.

A third alternative explanation of the discrepancy between evaluation and incidence of parasuicide in the HRA is that parasuicides and their families are enmeshed in a subculture whose content is somehow deviant from that of the subculture identified in the random control sample. This family subculture may express attitudes which are more positive or, perhaps, more extremely negative, to parasuicide than those found among the controls (i.e.

non-significant others). This hypothesis is indeed worth further elaboration and investigation. However, the CVI findings suggest that if the cultural meaning system of HRA parasuicides and their families is different from that of the general population in their area, the same difference is likely to be found in the LRA. In other words, we should be seeking the subculture of parasuicide, not in the social segment where low social class and high parasuicide rates intersect, but rather among parasuicides themselves. On the other hand, the influence of area of residence (LRA versus HRA) is more powerful as a main effect in most analyses than status group (patient versus control). On balance, the evidence points to the correctness of the decision to relate subculture to area populations and not status groups, and the unlikeliness of a deviant family subculture being found among parasuicides in the HRA alone.

A fourth alternative explanation of the evaluation/incidence discrepancy in the subculture is that parasuicide is not so much cultural behaviour at all, but rather an example of collective behaviour. In his discussion of the subculture/contraculture distinction as it relates to adolecent behaviour, Yinger (1960: 630) observes that:

> "there are currents of fashion or of other collective behaviour that sweep through an adolescent group, strongly influencing the behavior of its members. Although it is difficult to distinguish fashion from culture - many empirical phenomena have aspects of both - it is wise to keep them apart conceptually. This is not always done."

Quoting the statement by Havighurst and Taba (1949: 35) that "Boys

and girls, desiring the approval of their mates follow the fashions of the peer culture in morals, dress, and speech ...", Yinger notes:

> "If peer group influence stems from fashion, then strictly speaking it is not culture. The two differ to some degree in their origins, their functions, and their consequences."

The conceptualisation of suicide as collective behaviour has been fairly common. Durkheim (1952 (1897)) devoted a whole chapter of his work to the phenomenon of "imitation" in suicide (pp 123-142). He excluded situations in which reciprocal influence and fusion of individual states generate a sui generis collective reality acting as a force that impinges upon individuals in a crowd, causing them to act, think and feel alike. He also ruled out the sui generis pressure exerted by society upon the individual, causing him to conform to prevailing manners and morals. Rather, Durkheim restricted imitation to individual psychological phenomena occurring "between individuals connected by no social bond". The act occurs automatically in a mechanical, reflexive manner, without benefit of mental activity to link the stimulus (the act copied) and the imitative response. Durkheim freely admits that "[t]he idea of suicide may undoubtedly be communicated by contagion .... [S]uicides imputable to imitation ... are, it is true, very numerous. Perhaps no other phenomenon is more readily contagious" (pp 131-2). However, he distinguishes between moral epidemic and moral contagion, the former being "a social fact, produced by social causes", the latter consisting "only in more or less repeated repercussions of individual phenomena" (p 132).

"It does not follow a priori from the fact that suicide may be communicated from person to person that this contagious quality has social effects, that is, that it affects the social suicide-rate .... Imitation may give rise to more or less numerous individual cases, but it does not contribute to the unequal tendency in different societies to self-destruction, or to that of smaller social groups within each society" (pp 132, 140).

Durkheim also proposed a more general reason why the effects of imitation cannot be perceived statistically: "Imitation all by itself has no effect on suicide" (p 140). The thought of an act is not sufficient to produce the act itself unless the individual is already strongly predisposed to it. Consequently, Durkheim was highly sceptical of the proposal made by "certain authors" that the reporting of suicides in newspapers be prohibited.

"Such a prohibition might possibly succeed in slightly reducing the annual total of such acts. But it could hardly modify their social rate. The strength of the collective tendency would be unchanged, since the moral state of the groups would be unaffected by this." (p 141)

In recent years there has been a reawakening of interest in the topics of imitation, suggestion and contagion among suicidologists. On the whole their findings support Durkheim's contention that suicide is highly contagious. Thus, Phillips (1974, 1979; Bollen and Phillips, 1982) has established that a rise in overt and covert suicides follows highly publicised suicide stories appearing both in newspapers and on television news programmes. Ashton and Donnan (1981) report an "epidemic" of suicide by burning in England and

Wales following a widely publicised political suicide. Barraclough and colleagues (Barraclough et al., 1977) find a statistical association between reports of suicide inquests in a local paper and the subsequent suicide of men under 45 years. On the other hand, Motto (1967) hypothesised that suicide rates should fall during newspaper strikes because during those periods potential suicides would find no publicised suicides to imitate. Motto examined the suicide rates in seven cities undergoing newspaper strikes but found no evidence to support his hypothesis. Stack (1983) sought to assess the effect of the mass suicide of over 900 people in Jonestown, Guyana on the monthly American suicide rate. The results indicated no relationship between the Jonestown event and the national suicide rate. However, even where evidence for contagion is overwhelming, the key questions still remain unresolved: firstly, does suggestion merely serve to precipitate a suicide sooner than it would otherwise have occurred; and, secondly, does suggestion have only a negligible effect on the suicide rate?

The rapid and continuous rise in parasuicide rates in Europe and North America during the 1960s and early 1970s prompted a number of authors to talk about an "epidemic" (e.g. Matthew, 1966; Alderson, 1974; Lyons and Bindal, 1977). Kreitman (1977: 73) speculates that the rapid rise in admission rates for parasuicide in Edinburgh may be "at least partly due to 'contagious' case-to-case spread". Kessel, in his Milroy lectures, pointed out that "[t]he fashion has so developed over the last 20 years that today we regard it almost as commonplace" (Kessel, 1965: 1265). Stanley (1969: 194) believes that "Kessel is surely correct when he refers to the present spate of suicide attempts as fashion, and, if so, ..., the only preventive measure likely to have much chance of success would seem to be the

use of propaganda methods specifically designed to make the practice unfashionable again." The confusion between cultural and collective behaviour explanations of parasuicide is well illustrated by Evans (1967) and Mills et al. (1947):

> "[I]t may be that cultural factors are at least as important in determining the frequency and distribution of self-poisoning as individual psychopathology. If self-poisoning is largely a fashion, attention may be more profitably directed towards its "secondary prevention" ... than to the "primary prevention" of the stresses which precipitate it. It may be possible to replace the fashion by one less dangerous and less consuming of medical beds." (Evans, 1967: 105).

Mills et al (1974) speculate that the increase in parasuicide in Hobart between 1968 and 1972 "may be attributable in part to a contagion effect operating within high risk groups ..." (p 169). However, they conclude by suggesting that "[p]erhaps the most profitable approach [to primary prevention] lies in the manipulation of socio-cultural variables" (p 171).

My own data do not appear to support a contagion effect in parasuicide. Overall, similar proportions of patients and controls in both area-types report previous contact with suicidal behaviour. More importantly, parasuicides in either area do not appear to have had more such contact than their matched controls. By contrast, Kreitman et al. (1969) reported a four-fold excess of the observed to expected positive contacts (i.e. parasuicides) among patients admitted to the RPTC. However, it should be noted that positive contacts numbered only 17 out of a possible 578; and that

the "communication" hypothesis was formulated in the context of a sub-cultural analysis rather than a concept of "contagion" or "imitation". The topic clearly requires more investigation.

Two final possible explanations of the discrepancy between incidence and evaluation of parasuicide in the HRA relate to the methodology of the study. The first would claim that there is no necessary congruence between attitudes towards, and perceptions of, imaginary (case vignette) parasuicides, as measured by the CVI and other instruments, and attitudes towards, and perceptions of, actual parasuicides. That is to say, the various instruments may not be valid predictors of community attitudes and behaviours when significant others respond to the occurrence of a parasuicidal act. This possibility could only be tested using an alternative ethnographic, observational technique. The second possibility is that attitudes expressed on the CVI are not valid predictors of behaviour; that they have no consequences for behaviour and therefore have little influence on frequency or rate of parasuicide. Whatever the professed attitudes may be, the behaviour of the community to parasuicide implies a degree of toleration or acceptance. Here we can note the finding that patients in the HRA rate the evaluation of parasuicide by the local community as significantly less negative than controls do (and no such difference is evident in the LRA). This could support the hypothesis that HRA parasuicides perceive community views to be less hostile than in fact they are. On the other hand, views of parasuicides could equally well contain an element of post-hoc rationalisation or defence; and, anyway, both patients and controls in the HRA rate markedly towards the "proscribed" pole of the evaluative scale on parasuicide.

9.3 Conclusion

I began this Chapter with two key questions to which the study aimed to provide answers. The first concerns the existence of the putative subculture. Have I developed a reasonable case for claiming, on the basis of a limited number of face-to-face interviews with parasuicide patients and matched controls, that a high rate parasuicide area such as Pilton is characterised by a distinctive subculture? I would submit that the quantitative data obtained from the various instruments used in the investigation, together with independent evaluations of the Pilton area and ethnographic evidence gathered in other similar "dreadful enclosures", provide sufficient material for establishing the *prima facie* validity of such a claim. The study findings also provide support for the original decision to seek the existence of a subculture rather than a contraculture: that is to say, a meaning system which contains distinctive elements in addition to mainstream norms and values, a "stretched" version of the dominant culture rather than an entirely different cultural system altogether. However, when we move on to consider the *content* of the subculture (and therefore to answer the second key question posed at the start of this Chapter), we are confronted with results which are on the whole contrary to expectations. A number of the predicted central themes or tendencies of the high rate area cultural system were either absent or of lesser strength than had been anticipated. More crucially, the hypothesised tolerance or permissiveness towards parasuicidal behaviour in the high rate area was conspicuously lacking. A number of possible explanations were put forward for the discrepancy between the relatively greater frequency of parasuicide in the HRA and its more negative evaluation.

On the basis of these findings, it is tempting to suggest that we can discard the subcultural approach as a productive avenue for exploring and explaining geographical variation in parasuicide. I believe that such a conclusion would be premature and misguided. The multiple standardisation exercise of Buglass and colleagues established that the excess of parasuicide in certain city wards could not be wholly "accounted for" by the structural features of the area populations. In the absence of evidence which proves that the original results were artefactual (on account of the manner in which the standardisation exercise was carried out), then a subcultural explanation of the "area effect" remains plausible and worthy of further test. The final Chapter outlines a number of projects or lines of enquiry which derive from the findings of this study and which lie firmly within its sociocultural perspective.

Chapter 10 SUGGESTIONS FOR FURTHER RESEARCH

(1) Given the unexpectedness of the findings, especially in respect of the Case Vignette Instrument, a major first requirement would be the replication of this study in another high-rate parasuicide area, where there is an over-representation of working and lower class groups. The obvious choice of an alternative "dreadful enclosure" in Edinburgh which fulfils these criteria is Craigmillar, although there is every reason why similar areas in other major cities in Great Britain should be investigated in addition (or instead). Ideally, at least one other alternative methodology should be employed, possibly in addition to the survey-type approach adopted in this study. I have in mind here a more qualitative, ethnographic delineation of the subculture, using observational or participant observational techniques in the course of intensive and extended fieldwork.

(2) It has been hypothesised that areas like Pilton can be differentiated from other predominantly working class enclaves in other parts of the city on two major grounds: firstly, its status as a "dreadful enclosure" and the impact of its public reputation upon residents' self-image and self-evaluation; and, secondly, the absence of any countervailing normative system, such as would be characteristic of professional or more stable working class groups. The hypothesised subculture was not merely class-related but attributed to a specific class in a specific type of geographical area where other social classes were for the most part absent and residence in the area connoted a stigmatised or degraded status. It may then be fruitful to follow up the evidence (e.g. in Reiss and Rhodes, 1961; Clark and Wenninger, 1962) that differences in the social status structure of

residential areas may mean that the effects of a class status position are not uniform from one residential status structure to another. We need to investigate the independent effects of ascribed social status position and of social status structures on parasuicide rates and attitudes towards parasuicide. In practical terms, this might mean, for instance, comparing and constrasting cultural attitudes towards parasuicide and other officially deviant behaviour in two types of working-class neighbourhood: one being a typical "dreadful enclosure", the other being an enclave lying within or alongside a more respectable middle-class district. We would of course also be interested in comparing rates of parasuicide, etc., in the two area-types (some relevant data are already available), and the association between cultural attitudes and actual behaviour.

(3) A further possible development of the subcultural perspective would consist of small-group studies of parasuicide patients and their families. It is not possible to draw any conclusion from this study about the influence of subcultural factors upon the reaction to parasuicide among family members of actual parasuicide patients. Two key questions are: Do the parasuicide and his/her family share the same evaluations and perceptions of parasuicide? And does the parasuicide's family form a subcultural unit which is deviant compared to the dominant subculture within the class/area where it is located?

(4) The evidence suggests that parasuicide is a particularly deviant behaviour in the HRA, and I have put forward the proposition that its disvalued status is both recognised and understood by the area population. If it does indeed carry a "preformed message" (Kreitman, 1977: 66), the purpose of the communication may well be to convey not only despair, hopelessness, unhappiness, but also the urgency of

resolving the crisis and activating a rescue operation by significant others. These must remain speculations, because we still know so very little about the meaning of parasuicide to the actor and his/her significant others. It is difficult to envisage any great progress in the sociocultural perspective on parasuicide until we can develop methods for identifying the nature of the signal or communication contained in the act itself.

(5) A final new area of investigation originates in the hypothesis that the inverse relationship between social class and parasuicide reflects the influence of distinctive class-specific behavioural repertoires and cultural preferences on the approach to problem-solving and crisis resolution. A small-group study of parasuicides and their families from different social classes and geographical areas would concentrate upon the range and availability of other problem-solving behaviours in the immediate social milieu, the past family history of behavioural responses to crisis and stress, and alternative "coping" mechanisms. A start to this work has already been made by Parker (1981).

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APPENDIX 5.1

RPTC CODING SHEET

Appendix 5.1 RPTC Coding Sheet

CARD 2. PSYCHIATRIC INFORMATION 1979

*Factors predictive of further parasuicidal behaviour within next 12 months

CARD NO. 2 [1 2]

CASE NUMBER

Col. 2 3 4 5 6 7

No.

YEAR OF ADMISSION

..... 8 [7] 9 [9]

MONTH OF ADMISSION

1. Jan. 7. July
2. Feb. 8. Aug.
3. Mar. 9. Sept.
4. Apr. 10. Oct.
5. May 11. Nov.
6 June 12. Dec. 10

DATE OF MONTH (Adm.) 11

..... 12

HOUR OF ADMISSION (to Ward 3) 13

..... hours 14

(24 hour clock)

REFERRED TO R.I.E. by

12 N/K
11 N/A
1 G.P.
2 Psychiatric Hosp.—I.P.
3 Psychiatric Hosp.—O.P./D.P.
4 General Hosp.
5 Police
6 Samaritans/A.A.
7 Self
8 Other
15

SEX

N/K Male Female

12 1 2 16

AGE 17

.....yrs 18

AGE GROUP

12 N/K
1 < 15
2 15–19
3 20–24
*4 25–34
*5 35–44
6 45–54
7 55–64
8 65–74
9 75+
19

CIVIL STATE

12 N/K
1 Cohab.
2 Single
3 Married
4 Widowed
5 Sep/Living apart
6 Divorced
20

ADDRESS (usual home address)

Edinburgh District Code .....
(Code tens in Col.21, units in Col.22)

Edinburgh Polling District .....
(Code letters in Cols. 23,24)

OTHER ADDRESSES

Col. 21	Col.22 (Code 23, 24 as 11,11)	
7	1 Elsewhere in Lothian Region	
7	2 Elsewhere in Scotland	
7	3 Outside Scotland	
8	1 Resident in prison (one month or more)	21
8	2 Resident in psych. hospital (one month or more)	22
11	11 N/A	23
12	12 N/K	24

STUDENT (in full-time education)

12 N/K
0 Not student or school pupil
1 University or College
2 School
25

SOCIAL CLASS

Occupation .....

Employment status .....
(e.g. self-employed, foreman, etc.)

Record occupation as follows:
For MEN: Usual occupation, (if retired or unemployed, give previous occupation)
For SINGLE WOMEN (and div. and sep.): Usual occupation
For MARRIED WOMEN and WIDOWS: Husband's occupation
For STUDENTS and SCHOOL PUPILS: Enter "Student" under Occupation.

12 N/K
0 No usual occupation
1 Class 1
2 Class 2
3 Class 3(N)
4 Class 4
*5 Class 5
6 Class 3(M)
7 Student
8 Other
26

TYPE OF ADMISSION

12 N/K
11 N/A
0 Poisoning
1 Injury
2 Poisoning and injury
3 Delirium
4 Other incl. alcohol only
27

TYPE OF POISONING

12 N/K
11 N/A e.g. injury, alcohol only
0 Accidental
1 Deliberate—Poisoning not further specified
2 " Experimental ("Kicks")
3 " Complications of Habitual Misuse
4 Uncertain
28

TYPE OF INJURY

12 N/K
11 N/A e.g. Poisoning, alcohol only
0 Accidental
1 Deliberate
2 Uncertain
29

PRINCIPAL AGENT OF POISONING

Col 30	Col 31		Col 30	Col 31	
12	12	N/K	0	7	Barbiturates
11	11	N/A e.g. injury, alcohol only	0	8	Non-barbiturate hypnotics
0	0	Salicylates	0	9	Gas inhalation
0	1	Paracetamol	1	0	Non-ingestants
0	2	Other analgaesics legally purchasable	1	1	Other drugs
0	3	Opiates	1	2	Multiple agents
0	4	Antidepressants			
0	5	Phenothiazines, butyrophenones			
0	6	Minor tranquillizers			

30 31

SOURCE OF PRINCIPAL DRUGS

12 N/K
11 N/A e.g. injury
0 Non-prescribed drugs
1 Prescribed – for self
2 Prescribed for other
3 Illegal source
32

PRESCRIBED PSYCHOTROPIC DRUG TREATMENT
(being received prior to act)

12 N/K
0 No psychotropic drugs
1 Hypnotics only
2 Other psychotropics ± hypnotics
33

ILLNESS DIAGNOSIS

12 N/K
0 No psychiatric illness
1 Endogenous depression
2 Reactive depression
3 Organic psychiatric disorder
4 Schizophrenia
5 Epilepsy
6 Mania
7 Other (specify).....
34

PERSONALITY DIAGNOSIS

12 N/K
0 Normal personality
*1 Personality disorder
2 Subnormality
3 Drug addiction
4 Alcoholism
5 Other (specify) .....
35

PROBLEM IN USE OF ALCOHOL

12 N/K
*1 Chronic alcoholism with physical symptoms
*2 Alcohol addiction
*3 Excessive drinking
4 Not excessive within cultural norms
36

USE OF ALCOHOL AT TIME OF ACT

12 N/K
0 No alcohol taken
1 Drink taken, but sober
2 Drink taken, drunk
3 Drink taken, condition uncertain
37

HABITUAL MISUSE OF DRUGS (excl. alcohol)
(Code highest category)

12 N/K
11 N/A
*1 Intravenous administration
*2 Opiates, cocaine, L.S.D.
*3 Stimulant or sedative (e.g. amphetamine or barbiturate) – mainly from illegal sources
*4 Stimulant or sedative – mainly on prescription
*5 Stimulant or sedative – ? source
6 Cannabis
7 No misuse of drugs
8 Other
38

39

PREVIOUS IN-PATIENT PSYCHIATRIC TREATMENT

12 N/K
0 None
*1 I.P. at time of admission
*2 I.P. within previous week
*3 I.P. within previous month
*4 I.P. within previous year
*5 I.P. before last year
40

PREVIOUS OUT-PATIENT PSYCHIATRIC TREATMENT

12 N/K
0 None
*1 Day or O.P. within previous week
*2 Day or O.P. within previous month
*3 Day or O.P. within previous year
*4 Day or O.P. before last year
41

Card	CODE NUMBER								YEAR		Mth	Date of Mth		Sex		Type of Pois		Type of Inj	
3									7	9									
1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	17	18	19	20

SURNAME

21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40

FIRST CHRISTIAN NAME | ADDRESS CODE | (42) | (43) | U.D. | SUIC.

41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	79	80

PREVIOUS SELF-POISONING/INJURY
(admission to any hospital)

12 N/K
0 None
*1 One
*2 Two
*3 Three
*4 Four
*5 Five
*6 Six
*7 Seven
*8 Eight or more
*9 Yes but number N/K

42

PREVIOUS SELF-POISONING/INJURY
(NOT admitted to hospital)

12 N/K
0 None
1 One
2 Two
3 Three or more

43

NUMBER OF PREVIOUS ADMISSIONS TO WARD 3 FOR SELF-POISONING/INJURY

12 N/K
0 None
1 One
2 Two
3 Three
4 Four
5 Five
6 Six
7 Seven
8 Eight or more
9 Yes, but number N/K

44

MOST RECENT PREVIOUS ADMISSION TO WARD 3 FOR SELF-POISONING/INJURY

12 N/K
0 Never
1 Within previous 24 hrs
2 1 day< 8 days ago
3 8 days< 1 month ago
4 1 mth < 3 mths ago
5 3 mths<12 mths ago
6 12 mths < 2 yrs ago
7 2 yrs < 3 yrs ago
8 3 years +

45

CALENDAR YEAR OF MOST RECENT PREVIOUS ADMISSION TO WARD 3 FOR SELF-POISONING/INJURY

12 N/K
0 No previous admission
1 Admission in same calendar year
2 Admission in previous calendar year
3 Admission in earlier calendar years

46

PERMANENT SEPARATION FROM MOTHER
(death, divorce, desertion, etc.)

12 N/K
0 Not permanently separated
1 Permanent separation before age of 10 yrs
2 Permanent separation between 10 and 15 years

47

PERMANENT SEPARATION FROM FATHER
(death, divorce, desertion, etc.)

12 N/K
0 Not permanently separated
1 Permanent separation before age of 10 yrs
2 Permanent separation between 10 and 15 years

48

COMA LEVEL (from Card 1)

12 N/K
11 N/A
0 0
1 1
2 2
3 3
4 4

49

50

PRESENT HOUSEHOLD
(Items arranged in order of precedence)
Ring the first applicable number only,
i.e. if patient is living with spouse and parent(s) ring (1) – spouse; if living with parent(s) and sibling(s) ring (2) – parent(s)

12 N/K
11 N/A
1 Spouse
2 Parent(s)
3 Sibling(s)
4 Child(ren)
5 Other relative/friend
6 Lodgings/hostel
7 Institution
8 Alone
9 Other

51

VIOLENCE 1
(Patient known to have used excessive physical force on anyone in past 5 years)

12 N/K
11 N/A
1 Violent
2 Not Violent

52

VIOLENCE 11
(Patient known to have been subjected to excessive physical force from spouse or other relatives in past 5 years)

12 N/K
11 N/A
1 Violence received
2 Violence not received

53

PROBLEM IN USE OF ALCOHOL – SPOUSE OR COHABITEE

12 N/K
11 N/A
0 No complaints
1 Complains of spouse's drinking – no clear evidence of alcoholism
2 Complains of spouse's drinking – believed alcoholic

54

PSYCHIATRIC TREATMENT RECEIVED BY FAMILY MEMBERS

12 N/K
0 None
1 Father only
2 Mother only
3 Sibling(s) only
4 Spouse only
5 Child(ren) only
6 In-laws
7 Other combination

55

EPISODE OF SELF-POISONING/INJURY BY NEAR RELATIVE

12 N/K
0 None
1 Father only
2 Mother only
3 Sibling(s) only
4 Spouse only
5 Child(ren) only
6 In-laws
7 Other combination

56

COMPLETED SUICIDE BY NEAR RELATIVE

12 N/K
0 None
1 Father only
2 Mother only
3 Sibling(s) only
4 Spouse only
5 Child(ren) only
6 In-laws
7 Other combination

57

58 59 60 61 62

OVERCROWDING (number of persons per occupied room)

(a) Total no. of persons in household.....

(b) No. of rooms occupied by household.....

(c) No. of persons per room = $\frac{a}{b}$ .....

12 N/K
11 N/A e.g. lodgings, hostel, institution
0 1.50
1 1.51+

63

LENGTH OF TIME IN PRESENT JOB

12 N/K
11 N/A
1 Retired
2 Housewife only
*3 Unemployed
4 Employed in present job <1 year
5 Employed in present job 1 yr or more

64

65

DEBTS

12 N/K
1 Court action pending
2 Court action threatened
3 Arrears of payment (rent or other outstanding debts)
4 No debts

66

CRIMINAL RECORD

12 N/K
*1 Previously in prison – in past year
*2 Previously in prison – NOT in past year
*3 Conviction – in past year
*4 Conviction – NOT in past year
5 No previous criminal record

67

CURRENT POLICE PROCEEDINGS

12 N/K
*1 Police action currently threatened or in progres
2 Police action NOT threatened

68

RECOMMENDED PSYCHIATRIC DISPOSAL ON DISCHARGE

12 N/K
11 Patient not seen
0 None
1 In-patient detained
2 In-patient informal
3 Day Patient
4 Out-patient
5 S.W. only
6 G.P. only
7 Other

69

AGREED PSYCHIATRIC DISPOSAL ON DISCHARGE

12 N/K
0 None
1 In-patient detained
2 In-patient informal
3 Day patient
4 O.P. (R.I.E.)
5 O.P. (Elsewhere)
6 G.P.
7 Other
8 Died

70

AGREED PSYCHIATRIC DISPOSAL SOCIAL WORK

12 N/K
0 None
1 Hospital S.W.
2 Social Services Dept.
3 Health Visitor
4 Other

71

PSYCHIATRIC INTERVIEW

12 N/K
1 Patient seen by psychiatrist

Patient NOT seen by psychiatrist because:
2 Patient died
3 Premature discharge
4 Other reason

72

DOCTOR'S NUMBER
(Non-consultant staff)

73 74

E.P.C.R. NUMBER

75 76 77 78 79 80

USUAL HOME ADDRESS

Street . . . . . .

Town . . . . . .

MAIDEN SURNAME . . . . . .

APPENDIX 6.1

BACKGROUND DATA SCHEDULE

Appendix 6.1.

Case number [1][2][3]

Card number [3] [4]

Patient/Control [5] P = 1 C = 2

BACKGROUND DATA SCHEDULE

Name _____

Date of interview _____

Place of interview _____

Date of admission to RPTC (where applicable) _____

Date of birth _____ Age _____ years [6][7]

Sex 1 Male 2 Female [8]

Marital status

1 Single
2 Married - first ever
3 Separated/living apart
4 Divorced
5 Widowed
6 Married - second or subsequent
7 Married but living apart

[9]

Cohabiting?

0 No
1 Yes
9 Not applicable (rated '2' or '6' on Box 9)

[10]

Duration of present marriage/cohabitation

1 0-6 months
2 7-12 months
3 13-24 months
4 25 months - 5 years
5 6-10 years
6 11 years or more
9 Not presently married/cohabiting
8 N.K.

[11]

Place of birth

1 Scotland - Edinburgh
2 Scotland - elsewhere
3 England
4 Wales
5 Northern Ireland
6 Eire
7 Elsewhere (specify) _____

[12]

(If S moved around pre-age 16 and spent equal amounts of time in ⩾ 2 places rate where earliest years spent)

Place where most of childhood spent

1 Scotland - Edinburgh
2 Scotland - elsewhere
3 England
4 Wales
5 Northern Ireland
6 Eire
7 Elsewhere (specify) _____

[13]

Number of years in Scotland during lifetime _____ years [14][15]

(< 1 year = 01)

Education

0 Still in education
1 Left school with no qualifications
2 Obtained at least one CSE
3 Obtained at least one 'O' level
4 Obtained at least one Higher or 'A' level
5 Completed further education (university, polytechnic, teacher training)
6 Graduate work
7 Other (specify) _____ 16

Present/last occupation (specify in full)_____

_____

_____ 17

For men: if retired or unemployed, give previous occupation.
For single women: own occupation. If not working, give last occupation. If never worked, give father's occupation.
For divorced/separated women: own occupation. If not working, give last occupation. If never worked, give husband's occupation.
For married and cohabiting women and widows: husband's occupation, but if working also rate below.
For students and school children: give father's occupation.

(Working married and cohabiting women only) Present/last occupation (specify in full)

_____

_____ 18

(Coding: 0 Unclassifiable
1 I
2 II
3 IIINM
4 IIIM
5 IV
6 V
8 No information)

Present employment status

1 Working full-time
2 Working part-time (< 30 hours per week)
3 Employed
4 Unemployed
5 Retired
6 Housewife
7 Student
8 Inability pension (not economically active 19

(If 'off sick') How long? _____ weeks (NA = 99) 20 21

Number of months unemployed over past 5 years: _____ months 22 23

(Rate only if economically active - otherwise '99')

(If presently unemployed) How long is it since your last job finished/ since you finished your education? _____ months 24 25 26

(Rate '999' if not unemployed. If no previous job, rate '777')

How many jobs have you had over the past 5 years? N = ____ 27 28
(include present job)

(If never economically active during the period, rate '99', NK = 88)

Previous parasuicide

0 None
1 Yes - no medical treatment
2 Yes - medical treatment but not hospitalised
3 Yes - hospitalised (not RPTC)

29

Religion

1 Protestant
2 Catholic
3 Jewish
4 Other (specify) _____
5 None

30

Churchgoing (exclude special occasions)

1 At least weekly
2 At least monthly
3 At least once during the year
4 Never
(Rate over previous year)

31

Subjective social class

If you were asked to use one of these four names for your social class, which would you say you belonged in? The middle class, lower class, working class or upper class? (If child at home finds this difficult to answer, ask about FAMILY'S social class)

1 Lower
2 Working
3 Middle
4 Upper
5 Other (specify) _____
6 None (Don't believe in class)
8 NK/No answer

32

Household composition

	Name and relation to patient	Age	Occupation
1.	_____	___	_____
2.	_____	___	_____
3.	_____	___	_____
4.	_____	___	_____
5.	_____	___	_____
6.	_____	___	_____
7.	_____	___	_____
8.	_____	___	_____
9.	_____	___	_____
10.	_____	___	_____

Total N in household (including patient)

33 34

N adults (17+) in household (excluding patient)

35 36

N children aged 0-5 in household

37 38

N children aged 6-16 in household (excluding patient)

39 40

If patient in institution, lodgings, hostel, rate 77 above.

Type of household (Rate lowest possible number)

1 Living with spouse/cohabitee
2 Living with parent(s)
3 Living with child(ren)
4 Living with sibling(s)
5 Living with other relative/friend
6 Living in institution
7 Living alone (inc. lodgings, hotel)
8 Other (specify) _____ 41

Income

Net weekly household income from all sources: £_____ 42 43 44

(Calculate the average of the last four weeks)

(Where S is alone, calculate own net income) (888 = NK)

Present address _____

_____

(SEE SEPARATE SHEET)

Code: Ward 45

: Polling District 46 47

Accommodation: type of tenure

1 Owner-occupied
2 Rented from local authority
3 Rented from private landlord
4 Lodgings
5 Hostel
6 Living with friends/relatives
7 Co-ownership
8 Other (specify) _____ 48

Accommodation: type of housing

1 Whole house
2 Self contained flat in house
3 Room(s) in house
4 Flat in tenement
5 Flat in low-rise block on first three storeys of high-rise block
6 Flat in high-rise block (4th floor and up)
7 Other (specify) _____ 49

N living rooms (excl. kitchen, unless large enough to eat in) (9 = institution) 50

N bedrooms (9 = institution) 51

Income for self or household

0 Self
1 Household
8 Not known 52

N. days from admission to interview

_____ days (00 = same day; 99 = control) 53 54

Impulsivity of parasuicide

0 No decision
1 Decision made ⩽ 10 mins. before act
2 Decision made ⩽ 60 mins. before act
3 Decision made > 60 mins. before act
6 Informant doesn't know
7 Informant doesn't remember
8 Not known
9 Not applicable (control) 55

Planning of parasuicide

0 No prior planning
1 First planned < 24 hours before act
2 First planned ⩽ 1 week before act
3 First planned > 1 week before act
7 Informant doesn't remember
8 Not known
9 Not applicable (control)

56

Length of time at present address

_____ months (< 1 month = 001)

57 58 59

Previous address

1 Same polling district
2 Same ward
3 Other ward in Edinburgh
4 Outside Edinburgh - Scotland
5 Outside Scotland
6 Not applicable (born in same house)

60

N. addresses in past 5 years (inc. current one)

_____ addresses (88 = NK)

61 62

Place of interview

1 Home
2 RPTC
3 Psychiatric hospital
4 Other (specify) _____

63

Feel at home?

Is there an area around (here) where you are now living which you would say you belong to, and where you feel 'at home'?

0 No
1 Yes

"HOMEFEEL"

64

If answer is 'No' go to box 65, otherwise go to box 67

Where would you feel at home?

1 Elsewhere in same P.D.
2 Elsewhere in ward
3 Elsewhere in Edinburgh (specify) _____
4 Nowhere
5 Other (specify) _____
9 Not applicable

65

Do you feel an outsider where you live now?
Do you feel different in any way to other people living nearby?
(If 'Yes') In what way?

0 No
1 Yes (specify) _____
9 Not applicable

66

Subjective social class

I asked you before about what social class you felt you belonged in. What about the people who live in your neighbourhood? Would you say that most of them belong to one social class (which?) or to many? (which?)

1 Predominantly/completely lower class
2 Predominantly/completely working class
3 Predominantly/completely middle class
4 Predominantly/completely upper class
5 Mixed working/lower
6 Mixed working/middle or upper
7 Mixed lower/middle or upper
8 Don't know/no answer
9 Other (specify) _____ 67

Is there a sense of community where you live?

0 No
1 Yes - some (present to some extent
2 Yes - a lot (present to a marked extent) 68

Feelings about area when first moved in

1 Extremely happy
2 Quite happy
3 Didn't mind
4 Somewhat unhappy
5 Extremely unhappy
9 Not applicable (born in area) 69

Feelings about area now

1 Extremely happy
2 Quite happy
3 Don't mind
4 Somewhat unhappy
5 Extremely unhappy
8 Don't know "PRESFEEL" 70

Level of care (parasuicides only)

0 None after admission
1 Intermediate
2 Intensive care
8 Not known 71

(Controls not rated)

How interested are you to know what goes on in your neighbourhood?

0 No interest
1 Some interest
2 Strong interest 72

Do you know many people who live in your neighbourhood - even if just to nod to?

0 None
1 Few
2 Many, very many (>5) "AREAPEOP" 73

How many close friends do you have who live within ten minutes walk of your home?

N = _____ (9 = ⩾9) "AREAFRND" 74

How many relatives do you have who live within ten minutes walk from your home?

N = _____ (9 = ⩾9) "AREAREL" 75

Supposing that for some reason you had to move away from (here) where you now live, how sorry or pleased would you be to leave?

0 Not sorry
1 Quite sorry
2 Very sorry
3 Depends on where
4 Mixed feelings
8 Don't know

"MOVEFEEL" 76

Do you plan to move away from this area in the near future?

0 No
1 Possibly
2 Yes - but no concrete steps taken
3 Yes - steps taken to secure move
4 Yes - new home outside the area already secured
5 Already moved by time of interview
7 Would like to move but willing/happy to stay in the area

"MOVEPLAN" 77

Control number

(i.e. how many names needed to secure control interview)

(0 = Patient; 9 = 9 or more) 79

APPENDIX 6.2

VALUE ORIENTATION SCHEDULE:
INSTRUCTIONS TO RESPONDENT

Appendix 6.2. Value Orientation Schedule: Instructions to Informants

This questionnaire describes some 25 different problems or decisions which a person might face in life. For each problem or decision there is a choice of 2 or 3 possible solutions. I would like you to choose the solution which seems ideally the most preferable or desirable, regardless of what you or others actually do.

Read each problem over as many times as necessary to understand each of the suggested solutions and then make the choices asked for. In many cases you will no doubt be able to think of different and even better solutions to these problems. We ask you, however, to complete all questions from among the suggested alternatives only. Remember that this is not a test and there are no right or wrong answers to any of the questions. It's what you feel is right that counts.

APPENDIX 6.3

VALUE ORIENTATION SCHEDULE

Appendix 6.3 Value Orientation Schedule

Card 1
1 2 3
4 5 6
7 8
9 10

Q 1. Preferred way of life

Two people are talking about the way they like to live. Each has a different idea of the best way.

A. One says: What I care about most is doing things and getting things done just as well or better than other people do them. I like to see results and I feel it's worth working for them.

11 12

B. The other says: What I care about most is to be left alone to think and act in the ways that best suit the kind of person I am. Maybe I don't always get much done, but I can enjoy life as I go along. That's the best way for me.

13 14

Which of these two do you think has the more desirable way of thinking? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 2. Arrangements for housing estate

Imagine that the local council is planning a new housing estate in your area. Three people meet to discuss this and each one has a different idea about how arrangements - e.g. exact location - should be made.

A. The first person argues that the people of the area have already elected an MP and local councillors, and it should be left to them to oversee all the arrangements. They have the most experience and usually decide such things. 15 16

B. The second person argues that everyone in the area should have a say in matters concerning the new estate. Nothing should be done until there has been a long discussion and almost everyone is agreed about what's best for the community. As far as possible it should be a joint decision of all. 17 18

C. The third person argues that there should be discussion among as many people in the community as possible. But since individual views are important and they will differ, then the matter must be decided by vote. The views of the majority will prevail, even though there may still be a great many people who disagree. 19 20

Which person's view do you think the most right? _____

Which of the other two views do you find more right? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 3. Why men work

In order for life to go on there must be people who work. Yet there are different ideas about what keeps most men and women working.

A. Some believe that people don't really want to work. For the most part people are lazy and if given a choice would prefer to do no work at all. It is only the fear and discomfort of being without the necessities of life which keeps them working.

21 22

B. Some believe that people work and keep active because being busy with something useful gives them pleasure. They say that if people prefer not to work it's because they don't like the kind of work they have to do, and not because they prefer to do nothing.

23 24

Which of these ideas do you think is most right? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE AND DESIRABLE TO YOU.

Q 4. Bringing up children

Three people are talking about the way children should be brought up. Each has a different idea of the right thing to do.

A. One says: Children should be taught to behave just like we and our parents were taught. The old ways of doing things are the best and when children do not follow them, things start to go wrong. 25 26

B. Another says: Children should be taught something about the old ways of doing things, but they don't have to stick to these ways. Children must also learn new ways of doing things and adopt whatever of the new helps them to get along in the world of today. 27 28

C. A third says: Children don't really need to know how we and our parents did things. It's an interesting story that's all. The world goes along best when children are encouraged to find out for themselves new ways of doing things to replace the old. 29 30

Which of these people has the best idea about how children should be taught? _____

Which of the other two has the better idea? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 5. Future control of the weather

Three people are talking about good and bad weather and the things that control it. This is what each one says.

A. One man says: People have never controlled the rain, wind and other natural conditions and probably never will. There have always been bad years and good years. That's the way it is, and if you are sensible you will take it as it comes and do the best you can. 31 32

B. The second man says: I believe that it's man's job to find ways to control the weather just as we have overcome so many things. I believe we will one day succeed in doing this and may even overcome droughts and floods. 33 34

C. The third man says: I believe that we should try to adjust to different conditions, by learning to take good care of ourselves in case of floods or drought and to keep ourselves from being hurt by extreme heat and cold. 35 36

Which of these people do you think has the best idea? _____

Which of the other two people do you think has the better idea? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 6. Expectations re change in circumstances

Three people were talking about what they thought their children would have when they were grown up. They each said different things.

A. The first said: I don't know whether my children will be better off, the same, or worse off than I am. Things always go up and down even if people do work hard. So one can never really tell how things will be. 37 38

B. The second said: I expect my children to be better off in the future if they work hard and plan right. There are usually good chances for people who try. 39 40

C. The third said: I expect my children to have about the same as I've had. The best way is to work hard and plan ways to keep things as they have been in the past. 41 42

Which of these people do you think has the best idea? _____

Which of the other two has the better idea? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 7. Length of life

Three people were talking about whether we can do anything to make the lives of men and women longer. This is what each said.

A. The first one said: I believe that there is a plan to life which works to keep all living things moving together and if a man learns to live his whole life according to that plan, he will live longer than other men. 43 44

B. The second said: It is already true that scientists have found the way to add many years to the lives of most people by discovering new medicines, by studying foods and providing other things such as vaccinations. If people pay attention to all these new things they will almost always live longer. 45 46

C. The third said: I really do not believe there is much human beings themselves can do to make the lives of men and women longer. It is my belief that every person has a set time to live, and when that time comes it just comes. 47 48

Which of these three said most nearly what you think is right? _____

Which of the other two ways is more right? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 8. More leisure

In the future it is believed that men and women will have more and more free time. Different people have very different ideas about how good a thing this will be.

A. Some think that if people have enough money, more time free from work will be a wonderful thing. It can save people more time and energy to do things for pleasure and enjoyment. It can give them time to do the things they want to do.

49 50

B. Some people fear that more leisure will only provide greater opportunities for people to get into trouble. They believe that a busy person is likely to stay out of trouble while an idle person may get into more trouble.

51 52

Which point of view do you agree with most? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 9. Help in misfortune 1

A young couple get married and set up home together. While they're out one night a fire sweeps through their flat. The damage is extensive and it is quite out of the question for them to move back in. Three immediate possibilities of action seem open to them.

A. They can try to cope on their own, relying on their own resources or getting help from outside the family. They can insist on their rights to be assisted by the local housing department or even use their own savings to go into a bed and breakfast or hotel while things get sorted out. 53 54

B. They can go to a close friend or to a brother or sister. They are pretty much the same age and have always helped each other out in the past. 55 56

C. They can ask their parents to put them up while things get sorted out. After all, they have always relied on them up to now to help sort out their most difficult problems. 57 58

Which of these courses of action do you consider the right one to take? _____

Which of the other two ways do you think is more right? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 10. Attitudes to work

Imagine that two men or two women are talking about the way they like to live and especially their attitude to work. They are both alike in that each runs a small grocery shop, but their views are quite different.

A. The first one says: I don't like spending more time on my work than I have to. I'm happiest when the shop seems to run itself and hardly needs me at all. I like to have extra time to see friends, go out, take holidays, enjoy life. This is the way I like best. 59 60

B. The second says: I'm not satisfied with only doing the least I have to. I like best of all to find extra work to do so that I feel I'm doing a really good job. This means I don't have much time left over to be with friends, or go on holiday, or enjoy myself in other ways. But that's the way I really like best. 61 62

Which kind of person do you believe it is more desirable to be? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 11. Approaches to gardening

Three men are talking in a pub after spending a day on their allotments. Each one has a different way of planting and taking care of his vegetables.

A. One man plants his vegetables and then works hard on them, making use of all the new scientific ideas he can find out about. He feels that by doing this he will usually be able to prevent many of the effects of bad conditions. 63 64

B. The second man plants his vegetables, works hard and also tries to live in right and proper ways. He feels that it is the way a man works and tries to keep himself in harmony with the forces of nature that has the most effect on conditions and the way crops turn out. 65 66

C. The third man puts in his seeds and cuttings. Afterwards he works on them sufficiently but doesn't do more than necessary to keep them going along. He feels that how they turn out depends mainly on the weather conditions. Nothing extra that he does could change things much. 67 68

Which of these ways do you believe is usually best? _____

Which of the other two ways do you believe is better? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 12. Human troubles

We often hear or read about the trouble that people get themselves into and the trouble they cause others. Different people explain this in different ways.

A. Some say that people are naturally selfish and that they spend their lives looking out for themselves. For most it is only the fear of being found out and punished which keeps them from taking advantage of others.

69 70

B. Some say that people are not born either good or bad, but that they learn in growing up how they must be to get along. If life teaches them to be selfish, that is the way they will be. If it teaches them to be unselfish they can be that way too.

71 72

Which of these ways of thinking do you consider to be more right? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 13. Philosophy of life

People often have very different ideas about what has gone before and what we can expect in life. Here are three ways of thinking about these things.

A. Some people believe it best to give most attention to what is happening now in the present. They say that the past has gone and the future is much too uncertain to count on. Things do change but it is sometimes for the better and sometimes for the worst, so in the long run it is about the same. These people believe the best way to live is to keep those of the old ways that one can but be ready to accept the new ways which will help to make life easier and better as we live from year to year. 73 74

B. Some people think that the ways of the past are the most right and the best, and as changes come things get worse. These people think the best way to live is to work hard to keep up the old ways and try to bring them back when they are lost. 75 76

C. Some people believe that it is almost always the ways of the future - the ways which are still to come - which will be best. Even though there are sometimes small setbacks, change brings improvements in the long run. These people think the best way to live is to look a long time ahead, work hard, and give up many things now so that the future will be better. 77 78

Which of these ways of looking at life do you think is best? _____

Which of the other two ways do you think is better? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Card 2

1 2 3
4 5 6
7 8
9 10

Q 14. Help in misfortune 2

A young girl finds that she's pregnant. When her boyfriend realises this, he walks out on her. She is very upset and isn't sure about what she should do. Finally she can think of three ways of dealing with the problem.

A. She can talk over the situation with her closest friends and try to reach a decision which is agreeable to all of them.

B.. She can go to her parents or to another older relative and follow the advice they give.

C. She can face the problem herself and make up her own mind without consulting other people at all.

11 12

13 14

15 16

Which of these three ways do you think is best in this case? _____

Which of the other ways do you think is better? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 15. The teacher's job

Children spend almost as much time with their teachers as they do with their parents and yet there is still disagreement about just what the main job of the teacher is. Here are two different ideas.

A. Some people think that the teacher's job is to help the student think for himself, to teach him to make his own decisions and solve problems on his own. 17 18

B. Other people believe the teacher's main job is to decide, on the basis of her training as a teacher, what it is important for children to know and to see to it that it gets learned. 19 20

Which of these two ways do you think the teacher should aim for? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 16. Preferred way of working

There are three ways in which people who do not themselves employ others may work.

A. One way is working on one's own as an individual. In this case a man is pretty much his own boss. He decides most things himself and how he gets along is his own business. He only has to take care of himself. He doesn't expect others to look out for him. 21 22

B. Another way is to work for a company or a firm. The worker receives a wage in return for selling his labour power, but does not take any part in deciding how the business will be run. The boss or management take care of that side of things. 23 24

C. A third way is working in a group or collective fashion, where all the workers take all the major decisions together. The day-to-day running of the firm may be taken care of by elected delegates, but nobody is considered to be the boss. 25 26

Which of these three ways is usually best? _____

Which of the other ways is better? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 17. Man-god relations

There are different ways of thinking about how God is related to man and to all the natural conditions which make the crops and animals live or die. Here are three possible ways:

A. God and people all work together all the time. Whether the conditions which make the crops and animals grow are good or bad depends upon whether people themselves do all the proper things to keep in harmony with God and with the forces of nature. 27 28

B. Just how God will use his power over all the conditions which affect the growth of crops and animals cannot be known by man. But it is useless for people to think that can change what goes on in nature very much for very long. The best way is to take the conditions as they come and do as well as one can. 29 30

C. God does not directly use his power to controll all the conditions which affect man. It is up to the people themselves to figure out the ways conditions change and to try hard to find the ways of controlling them. 31 32

Which of these ways of looking at things do you think is best? _____

Which of the other two ways do you think is better? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 18. Expectations about family relationships

Three young people are talking about how different families organise their lives. They see that changes have been taking place - for instance, the part the man is expected to play in the home is not the same now as it used to be - and have different views about this.

A. The first person says: We should forget about old arrangements. What's best is the way of living that people work out for themselves, especially if this involves new approaches and ideas. There's nothing sacred about traditional and established methods. [33] [34]

B. The second person thinks that it's important to be aware of how families used to arrange things together. But that doesn't mean we necessarily have to stick to the old ways. We should also be open to new ways and new ideas as long as these enrich our lives. [35] [36]

C. The third person thinks it is better to stick to the old ways of doing things. These were the best. Change only causes difficulty and confusion, because then nobody knows what to do or what it's right to expect from others. [37] [38]

Which of these views is closest to what you believe is right? _____

Which of the other two views do you think is more right? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 19. Preferred way of spending the day

Two women are talking together about what they do during the day. Neither of them goes out to work and they live in similar circumstances. But they find they have very different ways of organising their time.

A. One woman says: I like to be busy all day long, doing all kinds of extra things in the house and getting involved in activities in the community. I don't have much time on my own just to sit and think, but that wouldn't give me much enjoyment anyway.

B. The other woman says: I'm happiest of all when I've done what's necessary to keep the house running smoothly. Then I'm free to sit and think, or just listen to the radio or talk with friends. That's my idea of a pleasant way to spend the day.

Which way of spending the day do you think is usually more desirable? _____

39 40

41 42

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 20. Responsibility for financial misfortune

A man is running a small family business. Various things start to go wrong - staff leave, sales fall off, and so on. In the end, the business goes bankrupt. Some people are talking about this and each has a different opinion.

A. One person said you just can't blame a man when something like this happens. There are so many things that can and do go wrong, and a man can do almost nothing to guard against things beyong his control. We all have to learn to take the bad with the good. 43 44

B. Another person said it was probably because the man had not lived his life right - had not done things in the right way to keep harmony between himself, his God and the world about him. 45 46

C. A third person said it was probably the man's own fault. He surely didn't use his head to prevent the loss of his business. They said that it is usually the case that men who keep up on new ways of doing things, and really set themselves to it, almost always find a way to keep out of trouble. 47 48

Which of these reasons do you think is most usually true? _____

Which of the other two reasons do you think is more true? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 21. Use of spare time

Two men are talking about how they spend their spare time. They are alike in many ways (e.g. the kind of job they have) but they have different views on what they find enjoyable outside their work.

A. One man uses his free time to be with other people or talk with anyone who happens to be around or do whatever comes into his head. He doesn't feel he has to accomplish anything. 49 50

B. The other man spends most of his time in activity of one kind or another - planning things, doing things, making things. He is happiest of all when he is kept busy and gets things done and can show he has achieved something by the end of the day. 51 52

Which kind of person do you think it is better to be? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 22. Community planning

Some people hear a rumour that the government may route a major trunk road through their community. Nobody knows whether this rumour is in fact true, or even if it is true, where exactly the road will be sited, who will benefit and who will suffer, and so on. There seem to be three different views about the matter.

A. One group says there's no point getting bothered about it. The road may not come anyway. If it does, then it's best to let the appropriate authorities decide, as they have always done. [53] [54]

B. A second group says: We must work out a plan now based on all the possibilities. We have to decide if we want the road or not. It's no good leaving it to others or putting off a decision until it's too late. [55] [56]

C. A third group says we should wait and see before deciding anything. Once we know just what is planned then we can come to a decision about what should be done. [57] [58]

Which of these three opinions do you think is the right one? _____

Which of the other two opinions is more right? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 23. Raising children

There have been many different ideas about how best to raise children.

A. Some say a child must be trained to consider anyone other than himself. He must be trained also to do things for himself and not to expect that others will always do things for him. Unless the child is trained he is likely to grow up thinking mostly about his own desires and expecting others to do the same. 59 60

B. Others say that if children are allowed to grow up in their own way and if they enjoy life while growing up they will naturally become as concerned about others as themselves. Also, they will want to do things on their own rather than have things done for them. 61 62

Which way of thinking about children do you consider the most correct? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 24. The husband-wife relationship

Three men are talking together after work. Although they have been married for about the same length of time and live in very similar circumstances, each clearly has a different relationship with his wife.

A. One man says: In our relationship I take all the responsibility for making the major decisions - for instance, about buying furniture or going on holiday. My wife expects me to behave like this and I think it's the right way too. 63 64

B. The second man says: My wife and I feel that the opinion of each of us is equally important. If we can't agree, for instance, about how to spend the evening, we are content to be different and go our separate ways. That's the right approach to the problem for both of us. 65 66

C. The third man says: My wife and I try to decide about everything together and do things together. If we seem to have different ideas on something, we talk until we can reach some agreement or compromise. We feel that's the best kind of relationship to have. 67 68

Which of these three ways do you think is the most right? _____

Which of the other two ways do you think is more right? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

Q 25. Preferred type of employer

A man was out of work and was offered employment by two firms. The attitudes of management were quite different in the two firms.

A. In one firm the management was reasonably fair and the rates of pay were above average, but the employee was expected to work extremely hard and stick on the job. If an employee frequently took time off for no good reason he was likely to be threatened with the sack (dismissal). 69 70

B. In the other firm only average wages were paid but management was not so firm. They understood that sometimes an employee would not be able to face coming in to work and would prefer to have an extra day off. They would not make a fuss or try and sack anyone who went absent in this way. 71 72

Which of these firms do you believe it would be better to work for in most cases? _____

REMEMBER: CHOOSE THE SOLUTION(S) IN THE ORDER WHICH SEEMS THE MOST PREFERABLE OR DESIRABLE TO YOU.

APPENDIX 6.4

WAYS OF BEHAVING INSTRUMENT:
INSTRUCTIONS TO RESPONDENT

Appendix 6.4.

WAYS OF BEHAVING INSTRUMENT

Instructions read to respondent before completion of Section 1

People differ in their opinions about right and wrong ways of behaving. I am interested in your own views about this. I would like you to think about average kinds of people living in your area and imagine them behaving in different kinds of ways. [Give examples from the list below.] What I want to know is: How do you feel about average kinds of people living in your area behaving in these different ways? Do you think they should do _____? Or do you think they should not? Or do you think that they are not obliged either to do _____ or not to do _____. In other words do you think it's up to them whether or not they do _____? If you feel they should do _____, then put a mark on the left side of the line. If you feel they should not, put a mark on the right side of the line. The stronger your feelings, the nearer your mark should be placed to the end of the line. So, if you feel very strongly that the average young married couple in your area should put aside money for future needs, you will place a mark near the extreme left end of the line. If you feel very strongly that they should not, the mark will go towards the extreme right end of the line. A very lukewarm feeling that people should not put aside money can be shown by putting a mark on the right of the line somewhere close to the centre. [And so on.] If you feel that there is no question of any obligation to put aside money, or not to put aside money, but that the average couple may or may not put aside money as they wish, then circle the mark in the middle of the line. If you really don't have any view at all, or can't make up your mind, or have never thought about the matter before, just put a tick in the "Not Sure" box.

WAYS OF BEHAVING INSTRUMENT

Instructions read to respondent before completion of Section 2

Now I would like you to think about these same different ways of behaving from another point of view. In the first section, you were asked to give your opinions about how average people in the area should behave. In this Section, I want you to give some impression of how you think average people in the area are actually likely to behave. If we take the first item again as an example, do you think it is likely that the average married couple in your area will put aside money for future needs? Or do you think it is unlikely? The more likely you think it is, the nearer your mark should be to the extreme left end of the line; the more unlikely, the nearer your mark should be to the right end. If you think that it's no more likely than unlikely that the average couple will put aside money, put your mark near the centre. Put a tick in the "Not Sure" box only if you are not willing to make a guess about how likely or unlikely the behaviour is.

APPENDIX 6.5

WAYS OF BEHAVING INSTRUMENT

Appendix 6.5. Ways of Behaving Instrument

1 2 3 4 5

WAYS OF BEHAVING

Name _____ Date _____

I. People differ in their opinions about right and wrong ways of behaving. We are interested in your own personal views about this. For each of the statements below we would like you to put a mark on the line to represent how you feel the average person living in your area should behave. If you are not sure, do not put a mark on the line, but tick the box on the right.

1	The average young married couple in my area ... put aside money for future needs.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
2	The average child in my area . . leave school at 16.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
3	The average married couple in my area ... quarrel and row with each other.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
4	The average young person in my area ... have sex before marriage.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
5	The average person in my area ... confide his/her problems to others.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
6	The average person in my area ... commit suicide or try to commit suicide.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
7	The average married woman with young children in my area ... go out to work.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
8	The average man in my area ... get into fights in the street.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
9	The average parents in my area ... severely beat their children when they behave badly.	Absolutely should	May or may not	Absolutely should not	Not sure ☐

10	The average person in my area ... vote in a general election.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
11	The average unhappily married couple in my area ... get a divorce or separation.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
12	The average young person in my area .. take a car for a joy ride.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
13	The average adult in my area ... settle an argument with fists (rather than with words).	Absolutely should	May or may not	Absolutely should not	Not sure ☐
14	The average person in my area ... get pills from doctor when feeling nervy or depressed.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
15	The average married couple in my area ... share their worries with each other.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
16	The average person in my area ... harm him/herself deliberately (e.g. by overdose of tablets or slashing wrists).	Absolutely should	May or may not	Absolutely should not	Not sure ☐
17	The average husband in my area ... help around the house.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
18	The average man in my area ... get drunk when he goes out with friends.	Absolutely should	May or may not	Absolutely should not	Not sure ☐
19	The average husband in my area ... batter his wife.	Absolutely should	May or may not	Absolutely should not	Not sure ☐

II. I would now like you to look at the list below of different ways of behaving. In your view, how likely or probable is it that the average person living in your area will behave in each of the ways listed? Please put a mark on the line to indicate whether each behaviour is very likely, very unlikely or somewhere inbetween. If you are not sure, do not put a mark on the line, but tick the box on the right.

				Not sure
1	The average young married couple in my area will put aside money for future needs.	Very likely	Very unlikely	☐
2	The average child in my area will leave school at sixteen.	Very likely	Very unlikely	☐
3	The average married couple in my area will quarrel and row with each other.	Very likely	Very unlikely	☐
4	The average young person in my area will have sex before marriage.	Very likely	Very unlikely	☐
5	The average person in my area will confide his/her problems to others.	Very likely	Very unlikely	☐
6	The average person in my area will commit suicide or try to commit suicide.	Very likely	Very unlikely	☐
7	The average married woman with young children in my area will go out to work.	Very likely	Very unlikely	☐
8	The average man in my area will get into fights in the street.	Very likely	Very unlikely	☐
9	The average parents in my area will severely beat their children when they behave badly.	Very likely	Very unlikely	☐
10	The average person in my area will vote in a general election.	Very likely	Very unlikely	☐

11	The average unhappy marriage in my area will end in divorce or separation.	Very likely	Very unlikely	Not sure ☐
12	The average young person in my area will take cars for joy rides.	Very likely	Very unlikely	Not sure ☐
13	The average adult in my area will settle an argument with fists (rather than with words).	Very likely	Very unlikely	Not sure ☐
14	The average person in my area will get pills from the doctor when feeling nervy or depressed.	Very likely	Very unlikely	Not sure ☐
15	The average couple in my area will share worries with each other.	Very likely	Very unlikely	Not sure ☐
16	The average person in my area will harm him/herself deliberately (e.g. by overdose of tablets or slashing wrists).	Very likely	Very unlikely	Not sure ☐
17	The average husband in my area will help around the house.	Very likely	Very unlikely	Not sure ☐
18	The average man in my area will get drunk when he goes out with friends.	Very likely	Very unlikely	Not sure ☐
19	The average husband in my area will batter his wife.	Very likely	Very unlikely	Not sure ☐

APPENDIX 6.6

CASE VIGNETTE INSTRUMENT:
INSTRUCTIONS TO RESPONDENT

Appendix 6.6.

Case Vignette Instrument - Instructions to Respondents

I would like you to read through the first page of this questionnaire. You will find a short description about something that happens to an imaginary person called Jane. Jane doesn't exist, although what happens in the story is based on real life. After reading the story you should then read through the statements below and place a tick in the appropriate column, depending on whether you "strongly agree", "agree", "strongly disagree", or "disagree" with each statement. If you really do not have any definite feelings about a particular statement you should tick the column "Not Sure". When you have given your opinions about all the statements in turn, you should then complete the other three pages in the same way. I would like you to think about each situation separately and judge each on its own merits.

APPENDIX 6.7

CASE VIGNETTE INSTRUMENT

Appendix 6.7. Case Vignette Instrument

1 2 3

Name _____ Date _____ 4

Case 1 - Mary 5

Mary McClelland is 35 years old. She and her husband Arthur have run a busy pub for ten years. Recently they've been very short staffed and Mrs. McClelland has become very tired and depressed. She's been getting angry with Arthur, who she feels doesn't give her the support she needs and makes no attempt to understand her. She's tried explaining this to him but says he doesn't seem to take any notice.

Mary had been looking forward to a day's outing with an old friend from her home town, but at the last minute it fell through. Mary was upset and annoyed. She went to Arthur in a state, but Arthur thought she was being irritable again and walked away instead of giving her the sympathy she wanted.

Mary had a few drinks by herself, and then went back to her room; there she found a bottle of Arthur's pills and started to swallow them. Arthur, who had followed her, took the rest of the pills away and called the doctor.

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
1 Given her situation, it was understandable for Mary to do what she did.					
2 Mary should be punished in some way for what she did.					
3 Mary did the right thing under the circumstances.					
4 Mary could not help doing what she did. It was something that just happened to her.					
5 Mary really wanted to die when she took the pills.					
6 Given the same problems, any woman might do what Mary did.					
7 What Mary did was morally wrong.					
8 What Mary did was one possible way of dealing with her problems.					
9 Mary was trying to commit suicide.					

Name _____ Date _____

1 2 3 4 5

Case 2 - Frank

Frank Martin is a 55-year-old consulting engineer. Two years ago he was given the 'golden handshake' by the firm he had worked with for many years. Although he was upset at the time he planned to work on his own, but this freelance work has not gone well and much of the time he spends at home doing nothing. His wife is a forceful personality, several years younger, and has a successful career as a buyer in a large firm. At the moment she is the main breadwinner. The relationship between her and Frank has been poor for some time. She frequently criticises him for his inability to get going, and there are frequent rows and very little warmth between them.

Frank has felt increasingly depressed, withdrawn and hopeless about the future. He is always reluctant to seek help. On the day of admission to hospital his wife returned home from work, heard a noise in the garage and found Frank unconscious on the floor of the garage with the car engine running and the doors closed. He regained consciousness in hospital.

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
1 Given his situation, it was understandable for Frank to do what he did.					
2 Frank should be punished in some way for what he did.					
3 Frank did the right thing under the circumstances.					
4 Frank could not help doing what he did. It was something that just happened to him.					
5 Frank really wanted to die when he gassed himself.					
6 Given the same problems, any man might do what Frank did.					
7 What Frank did was morally wrong.					
8 What Frank did was one possible way of dealing with his problems.					
9 Frank was trying to commit suicide.					

Name _____ Date _____ 1 2 3 4 5

Case 3 - Joe

Joe MacDonald is 45 years old and was recently admitted to hospital in an intoxicated state with an overdose of aspirin. He had phoned the hospital saying he was going to kill himself, but had put the receiver down without saying where he was. The call was traced, however, and he was brought into hospital by the police. That morning he had been evicted from his lodgings because of drunkenness.

At one time he had been a regional sales manager with a good salary, but at the time of his admission he was unemployed. His last job, as a long distance lorry driver, had ended nine months previously when he lost his driving licence because of drunkenness. This was followed by a large overdose of sleeping tablets. Since that time, he had had two further admissions to hospital with overdoses, each following the break up of a relationship with a woman. He always had difficulty in forming a stable relationship. At this moment he would like help but doesn't see what anyone can do for him.

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
1 Given his situation, it was understandable for Joe to do what he did.					
2 Joe should be punished in some way for what he did.					
3 Joe did the right thing under the circumstances.					
4 Joe could not help doing what he did. It was something that just happened to him.					
5 Joe really wanted to die when he took the pills.					
6 Given the same problems, any man might do what Joe did.					
7 What Joe did was morally wrong.					
8 What Joe did was one possible way of dealing with his problems.					
9 Joe was trying to commit suicide.					

Name _____ Date _____ 1 2 3 4 5

Case 4 - Jane

Jane Brown is an 18-year-old telephonist who lives with her parents. She gets on well with her father, but not with her mother. They often argue, and Jane feels she cannot confide in her mother. For some time she has wanted to get away from home and lead a more independent life. She is very much looking forward to getting married.

She has been going steady with her boyfriend Ron for about nine months and has certainly hoped to marry him. Recently, however, things have not been going well between them - they have been arguing a lot and Ron seems to be less interested in her. On Saturday night they went to a party together. Soon after getting there Ron more or less ignored her and spent most of the evening dancing with other girls. Jane became very upset and left on her own. She walked around the town for some time before returning home. When she got home her mother came out of her room and criticised her for being so late and asked where she'd been. Jane started to argue, but then quickly went into the bathroom and swallowed a number of her mother's sleeping tablets. Her father came into the bathroom, found what had happened, and took her to hospital.

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
1 Given her situation, it was understandable for Jane to do what she did.					
2 Jane should be punished in some way for what she did.					
3 Jane did the right thing under the circumstances.					
4 Jane could not help doing what she did. It was something that just happened to her.					
5 Jane really wanted to die when she took the pills.					
6 Given the same problems, any woman might do what Jane did.					
7 What Jane did was morally wrong.					
8 What Jane did was one possible way of dealing with her problems.					
9 Jane was trying to commit suicide.					

APPENDIX 6.8

CONTACT WITH SUICIDAL BEHAVIOUR

Appendix 6.8.

Patient number [1][2][3]

Card number [4]

P or C [5] P = 1, C = 2

CONTACT WITH SUICIDAL BEHAVIOUR

Name _____

Date _____

A. Contact with threatened (para)suicide

(i) Have you ever heard about anyone who threatened to hurt him/herself deliberately or take his/her life (e.g. by overdose of tablets, or by cutting the wrists, or by gas, etc.)?

- Was s/he a friend or relative?
  (specify _____)
- How did you hear about it?
  (specify _____)
- When?(specify _____)

(ii) Have you ever been personally involved* when someone threatened to hurt himself/herself or take his/her life?

- Was s/he a friend or relative?
  (specify _____)
- How were you involved?
  (specify _____)
- When?(specify _____)

B. Contact with actual parasuicide

(i) Have you ever heard about anyone who deliberately harmed him/herself or attempted suicide (e.g. by overdose of tablets, or by cutting the wrists, or by gas, etc.)?

- Was s/he a friend or relative?
  (specify _____)
- How did you hear about it?
  (specify _____)
- When?(specify _____)

(ii) Have you ever been personally involved* when someone deliberately harmed him/herself or attempted suicide?

- Was s/he a friend or relative?
  (specify _____)
- How were you involved?
  (specify _____)
- When?(specify _____)

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* PERSONAL INVOLVEMENT entails at least one of the following: being physically present at the time of the act, being in telephone contact at the time of the act, being advised immediately beforehand, finding the person immediately after, being told immediately after.

C. Contact with suicide

(i) Have you ever heard about anyone who actually committed suicide?

- Was s/he a friend or relative?
  (specify _____)
- How did you hear about it?
  (specify _____)
- When?(specify _____)

(ii) Have you ever been personally involved* when someone committed suicide?

- Was s/he a friend or relative?
  (specify _____)
- How were you involved?
  (specify _____)
- When?(specify _____)

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* PERSONAL INVOLVEMENT entails at least one of the following: being physically present at the time of the act, being in telephone contact at the time of the act, being advised immediately beforehand, finding the person immediately after, being told immediately after.

	N Persons	N Events	Time since most recent event**
Has heard about someone threatening parasuicide (no personal involvement) - not friend/relative*	6	7	8
Has heard about someone threatening parasuicide (no personal involvement) - friend/relative*	9	10	11
Has been personally involved when other (not friend/ relative) threatened parasuicide*	12	13	14
Has been personally involved when friend/relative threatened parasuicide*	15	16	17
Has heard about someone committing parasuicide (no personal involvement) - not friend/relative	18	19	20
Has heard about someone committing parasuicide (no personal involvement) - friend/relative	21	22	23
Has been personally involved when other (not friend/ relative) committed parasuicide	24	25	26
Has been personally involved when friend/relative committed parasuicide	27	28	29
Has heard about someone committing suicide (no personal involvement) - not friend/relative	30		31
Has heard about someone committing suicide (no personal involvement) - friend/relative	32		33
Has been personally involved when other (not friend/ relative) committed suicide	34		35
Has been personally involved when friend/relative committed suicide	36		37

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* If threatened parasuicide led to actual (para)suicide on the same occasion, do not record here

** Rating:
0 No events
1 $<$ 1 week
2 1 week $\leq$ 1 month
3 1 month $\leq$ 3 months
4 3 months $\leq$ 6 months
5 6 months $\leq$ 1 year
6 $\geq$ 1 year

APPENDIX 6.9

PWB SCALES

Appendix 6.9.

1 2 3 ☐☐☐

PARASUICIDE VALUES PROJECT

4 5 6 ☐☐☐

P.W.B. Scales

Name _____ Date _____

During the past few days have you felt:

Q 1. Bored? ☐

Q 2. Particularly excited or interested in something? ☐

Q 3. Upset because somebody criticised you? ☐

Q 4. That things were going your way? ☐

Q 5. Very lonely or remote from other people? ☐

Q 6. Proud because someone complimented you on something you had done? ☐

Q 7. On top of the world? ☐

Q 8. Pleased about having accomplished something? ☐

Q 9. Depressed or very unhappy? ☐

Q10. So restless that you couldn't sit long in a chair? ☐

Code: 1 - Yes; 0 - No.

Positive affect scale: Total score for Q2, Q4, Q6, Q7, Q8 (0-5) ☐

Negative affect scale: Total score for Q1, Q3, Q5, Q9, Q10 (0-5) ☐

Affect Balance Score (range 0-10) (PAS - NAS + 5) ☐